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ABSTRACT

As described at a 1969 conference and summarized here, the training and use of nonprofessionals in the demonstration program (1962-68) of the Dona Ana Mental Health Services, New Mexico, represented a significant change in structure, manpower utilization, and delivery system for such services. The conference itself reviewed such aspects as staffing and organization, client characteristics, client satisfaction, training concepts (aimed at the "here and now" problems of emotional disturbance rather than at patient histories), and project impact on the community and state. Community projects consisted of an answering service (the Crisis Center), a youth council, an alcoholism program, and creation of a center for retarded and emotionally disturbed children. There was discussion as to what program elements had been useful and were more widely applicable. (Appendixes contain two references, agenda and roster, background information, role descriptions, conference evaluations, abstracts of research findings, and retrospective judgments on various phases of subprofessional training and utilization.) (ly)

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UTILIZATION OF NON-PROFESSIONALS
A Conference Report

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As Demonstrated by Dona Ana Mental Health Services:
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The Dona Ana Mental Health Services project, "Training Non-Professional Community Project Leaders," and the conference held in March, 1969, to report the findings of that project were both supported in part by Public Health Services Grant MH14821 from the National Institute of Mental Health.

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Foreword

Change is the keynote of modern society. In all significant areas of our society, in transportation, communication, education, technology, and even in the "human services" area, we have been experiencing a period of rapidly accelerating change. But change without critical analysis, change without opening up the experience to the scrutiny of relevant practitioners and educators, and change without open and honest communication so that others may also learn what we have learned, is likely to be rather sterile and of limited usefulness.

This is what the conference held in Las Cruces, New Mexico, on March 10-11, 1969, was all about. The experimental program of the Dona Ana Mental Health Services, described in detail at the conference and summarized in these pages, represented a significant change in the structure, the utilization of manpower, and the delivery system for mental health services. Feeling that the experience of those relatively few persons who personally lived this experience needed to be shared with others separated by hundreds or thousands of miles, but bound to us by a common concern about the inadequacies of many of our current approaches to providing community mental health services, the DAMHS program staff committed themselves to "lay it on the line". The idea of a national conference to which persons from all over the country whose own work clearly reflected concerns common with that of the DAMHS program could be invited was born. We are deeply grateful to the NIMH for its encouragement and support which allowed the idea to become a reality.

It is our hope that conference participants were enabled to learn about and to "feel" the DAMHS program not only through their own eyes, but to some extent through the eyes of those who lived the experience. We hope also that the conference experience will allow participants to assess the strengths and weaknesses of the program, and to (most importantly!) abstract and use whatever of the DAMHS experience will aid and strengthen their own efforts all over the country. The extent to which our hopes were fulfilled can best be judged by the reader from the presentations and the discussion reported in the following pages, and by the summary of the post-conference evaluation responses included as appendix VII. We are pleased to have been able to host such a conference, and we are delighted to present this report. We hope this will be an additional means of sharing our program experience with many more than the relatively few persons who could meet with us in person in Las Cruces.

Jerome Levy, Ph. D.
Conference Co-Chairman

Utilization of Non-Professionals in Community Mental Health Projects as Demonstrated by Dona Ana Mental Health Services

Background

Lester Libo, C. Elizabeth Madore and William Sears

Dr. Libo: I'm not really sure I like the role I'm in at this conference because it makes me feel just slightly younger than Coronado. I've been in New Mexico longer than anyone I know, and am not called on to describe what I am now doing, but to give the grandfatherly background. At any rate, in 1957, I came to New Mexico in the position of director of the division of mental health of the state health department, with the goal of developing a statewide community mental health services program in a state which could have been called an underdeveloped area. New Mexico had no graduate training facilities for any mental health discipline. It had one part-time child guidance clinic in Albuquerque, staffed largely by volunteer professionals. It had one state hospital and a tradition of looking to the state hospital as its only mental health resource. Statistically, New Mexico had the lowest occupancy in the state mental hospital in the country, but one of the highest rates of institutionalization in the state penitentiary. It had the frontier tradition: rugged individualism, a suspicion of federal programs, of welfare and even of the state in some local communities. There was an early display of extremist thinking, making this among the first areas where those associated with mental health were accused of being communists and brain-washers. Another feature of our lot was all state mental health funds went to the state hospital. We were on the minimal federal formula grant which at that time was $20 thousand a year for the whole mental health program.

I came here with a background of academic and research centers. I was a psychologist. I still am, I guess, though I consider myself more of a general "mental-healther" than a representative of a particular discipline. The prospect of working in the state, in spite of the introduction I have given you, was quite exciting. New Mexico was a frontier and the whole community mental health movement was a frontier topic. One could feel he could do almost anything here. There wasn't a hard and fast tradition of rigid jurisdictions, disciplinary lines, and ways of doing things. I was working with adventurers and mavericks.

The first step was to look at what had been done in the state to try to serve this very large area which had widely dispersed population centers. Some years before I came, the entire state mental health program was based in a child guidance center in Santa Fe, which did not reach out, travel, or do much community development. The next thing tried was a traveling team, based in the mental health division of the department of public health in Santa Fe. This team, composed of a pediatrician who had about a year's training in psychiatry, a master's level psychologist and a master's level nurse-mental health consultant, did travel all over the state. They would generally stay in an area for three or four days. School guidance, school nurses, and perhaps a probation officer or judge would save up troublesome or troubled cases and consult with this traveling team. The team would do diagnostic work, make recommendations, and go back to Santa Fe. This pattern existed for about five years before 1957.

By this time, some minimal state funds were used to support the beginnings of some little local programs. For example, there were funds given to two or three of the state colleges to give students a dollar an hour for testing some kids. But in the more than five years of this traveling team pattern, there was no really viable local program developed. Just before I came, a state health department advisory board consisting of two psychiatrists and a professor of law decided the old pattern would not do. They gave me, as my first task, the unhappy job of advising these local centers their funds would be withdrawn, and we were going to work out another pattern. When the state funds were withdrawn from the little scattered programs, they folded. We started fresh.

Fortunately, I had the freedom to work out the new pattern. I traveled all over the state, met pretty much cold with people who would have some interest in mental health. I'd arrive in town, go to a phone booth, and call the superintendent of schools, or the judge, or the welfare director. I had something to sell, though there wasn't a specific package, but a request to meet and talk about mental health, what was going on, what problems they had, and what ideas they had. I felt like a combination missionary and union organizer.

It was interesting that all communities expressed satisfaction with the traveling team. They had found them dedicated and helpful; they liked them. But the communities were largely resourceless and at a loss. They wanted something more stable. They defined their need as someone to organize them to organize a mental health program. There was no one to do this.

Through a personnel survey of the state, we found there were 90 people in the state in mental health positions, all in private practice or agency jobs which took all their time. Of the 90, less than half were trained at the full level of their respective disciplines. Most were in direct case services. There was nobody to become a local community mental health organizer or director.

The format conceived as a solution to the problem was taken from the agricultural extension service model of the county agricultural agent; that is, a person whose full time responsibility was to serve as a consultant, a developer. He would not farm the land himself; he would not do all the therapy himself. He would try to organize what community resources there were and serve as an expert consultant or community developer. Most communities felt this was better than nothing; it would give them someone who could help organize and eventually bring in other resources. But the professionals, who had many cases piled up, wanted to get rid of responsibility for the cases and wanted clinics. Our funds permitted only one person in an area, and of course we couldn't have clinics.

Looking at the map of New Mexico, you will note a bull's eye concentration of populated areas around Albuquerque and a periphery of outlying communities with very little between. The state was divided into eight districts; we decided to concentrate on four for the county agent approach. We selected the four on several bases. They were on the periphery. The areas had sizable populations but, with the exception of a psychiatrist in private practice in Roswell, no mental health services. We wanted evidence of local interest. We wanted the local health officer to be in favor of the program and support it. The office of the consultant was to be placed in the district health department, and based in the county health departments around the district. Each district had between two and a half and four counties. We wanted four districts which would provide a contrast in terms of ethnic groups and economy. Next, we wanted some kind of assurance a small amount of matching funds would be raised by the local district. We estimated the cost at about $20 thousand per year per district, so we asked each district to raise $4,800 from school contributions, public health contributions, local mental health associations, etc.

The four consultants hired were a mental health nurse consultant, two psychologists, and a psychiatric social worker; we were flexible about disciplines as long as we had three represented. All of these mental health consultants were beyond the terminal level of their respective disciplines: that is, the nurse consultant and the social worker had master's degrees, the psychologists Ph.D.'s, all had more than five years experience as both clinicians and community workers. The consultants were backed by once-a-month consultation by the program's psychiatrist, Dr. Sears.

The role of the four consultants included the following: (1) Community mental health facility development; (2) public information and education; (3) case consultation and training to community care-givers; (4) some direct service, mostly as demonstration for in-service training. An attempt was made not to take patients away from others but to maintain responsibility for casework where it was. If some caregiver could not continue with a case, the mental health consultant would help with a referral.

This county agent format was a four-year program, funded by NIMH under one of the early community mental health project grants. It turned out to be a possible format for underdeveloped areas using just one local-resident community developer professional expert who would live in the community, develop its resources and new resources according to the needs of that community.

The consultants developed interesting kinds of programs in the various districts: a home visiting and counseling service using a public health nurse, projects with clergymen and law enforcement officials, a family consultation service, a school for retardates, and here in Las Cruces, a second year public school check-up, a school for severely emotionally disturbed children, and the Dona Ana Mental Health Services, the project that has to do with our present interest of using indigenous non-professional workers.

Our philosophy was that it does not take formal psychotherapy to make contact between care-givers and clients therapeutic. We did feel we should have experts somewhere in the picture to coordinate, consult and teach, but that most therapeutic influence is carried out by people in the mainstream of community life. As long as they are given support, consultation and some training by the mental health expert, a lot of good can be done. When you look at the list of facilities developed including new agencies, you can see that even one person working in a community alone can accomplish a great deal (Libo & Griffith, 1968). It is from this background that our present interest has come.

Miss Madore: The period of time covered by the Dona Ana Mental Health Services project was from conception in 1962 to termination in 1968.

I came to New Mexico from New York as the nurse-mental health consultant for the Southern District under the program just described by Les Libo. There was, throughout that project, always the hope that something would develop nationally or on a state level that would help supplement projects being developed in the communities. By 1962, it became obvious that this was not going to materialize.

At that time, the state of New Mexico had been operating the basis of its mental health program with funds from the grant described by Dr. Libo, which was running out. Las Cruces had been very responsive to the kind of program which Dr. Libo had helped initiate. Patients were coming in at the rate of about 300 a year; agencies increasingly were using consultation. Some special projects in public schools and courts had been started, but it was very difficult to determine priorities. Volunteers were willing and helpful, but most of their attempt served only to highlight the needs of the population. There were very few professional people in the area; these were employed in meaningful positions. Attempting to start a project staffed by professionals did not appear possible, even if we had funds.

Kennedy's message on mental health and mental retardation had been given during 1962, but there was yet no legislation to implement it. You will remember, the Joint Commission Report on mental health and mental illness had also been published. In it, Jack Ewalt said:

> The desire to develop mental health resources is everywhere, but there is not enough consultation and local planning. The manpower situation. . . is so critical

> that there is not enough manpower to staff many of the areas ready to create services. . . Every effort must be made to provide non-psychiatrically trained persons as knowledgeable as possible. They must be given all the tools they can use, particularly competent and expert consultation. . . However you look at it, the numbers of psychiatrists, psychologists, social workers, nurses and occupational therapists are inadequate and will remain inadequate in numbers in the foreseeable future. To provide care for our patients will require extensive use of sub-professional personnel.

The statement sparked us. It looked as if there might be a real resource in the volunteers I mentioned earlier. However, I had not been able to plan my time to adequately help them express their potential. These people would need a structure, to be taught, to be supported. They would need to be committed to spend enough time with us so the experiences we had to offer them would add up. The true resource for mental health workers for Las Cruces did seem to lie right here in Las Cruces.

We were aware of two programs that were training non-professional people for mental health roles: the Rioch project, which utilized housewives as therapists; and the Florida project, which utilized semi-professional people such as public health nurses and teachers as part of the mental health manpower force. Both Dr. Sears and I had some experience in working with non-professionals, teaching some of the basic mental health skills to people who did not have specific training to do mental health work. Each of us had been impressed with the contributions of these people who had only a minimum of training. We felt that given a choice between a professional person who lacked a therapeutic-type personality and some non-professionals, we would choose to work with the non-professionals.

The role we visualized for a non-professional worker grew out of the four-part community consultant role with which I had been working. It differed in that each trainee would be assigned a specific area of the total mental health role. This would allow him to become completely knowledgeable about his special area. He would then be a community project leader: develop a wanted community facility which would conflict with no existing facility. He would do public education. He would serve as a trainer to his volunteers. He would involve other care-givers in handling clients in a coordinator role. He would offer services directly, but mostly indirectly. He would be a developer rather than a traditional therapist.

My community coordinator role had had a fifth injunction: to live in and be involved in the community. As part of the criteria for selecting trainees, we wanted people who were committed here, who did not want to move, and who were known here. We wanted them to have the kind of characteristics that would help them become community organizers. We wanted people with the capacity to understand mental health literature, its aims, and ways to relate it to the problems of the population. We wanted mature people who had learned how to live through a rich life experience.

Our training could be geared to add to this life experience. We did not plan a structured program, but rather one that would be responsive to the needs of these people, and would help them with the kinds of jobs and roles they saw could help them to become self-actualizing.

Dr. Sears: The feelings and thinking that nourished the evolution of Dona Ana Mental Health Services stemmed from several forces: (1) Las Cruces' need for service; (2) its lack of treatment resources and professional personnel; (3) the trend developing in the mental health field moving it toward better services through coordination of services, education, consultation and pilot project efforts at new program development; (4) a persistent awareness that the current federally funded, time-limited project would soon run its course; and (5) an increasing awareness of the potential of the people to contribute to the solution of the community's mental health needs. Volunteers, both professional and non-professional, had indicated a willingness to help. We lacked a structure which would allow us to promote their involvement in an effective and sustained manner.

The research aim of the project was to study ways of using non-professional potential to meet mental health needs. The organizational-service aim was to build a structure which would allow for attracting, training, supporting, and coordinating community potential to meet its own needs. Initially, one of the aims was to become known, win friends, and gain support. Our goals, as we then understood them, were to fit with and add to existing services. The program was, in part, a community supplement to state programs such as the state hospital and the hospital for mental retardates. The program was also, in part, for development of new resources. The plan was to develop community based services related to the needs of the community, simultaneously with offering service to individuals in need. Finally, the project was to teach the community through its participation in mental health activities what mental health problems are, and how individuals may contribute — their time, their resources, and their influence — to alleviate the problems.

The aims have much in common with those of some programs from which we differ a great deal. Since a project is only realistically evaluated against its own goals, we would like to point out what DAMHS was, and was not intended to be.

The project was administered by a non-profit organization, Dona Ana Mental Health Services, developed and structured specifically to administer this study. The project was not an OEO program, related to or demanded by the political structure, an official branch of the division of mental health, or property of an agency or discipline.

The project was to serve the needs of a total community which had no services for its population. It was not to solve one particular social problem, or to work with any one segment or slice of the community such as the poor. It did not exclude any referral because the client was too rich or too poor, and it worked with individuals from four ethnic groups in the area.

The project had only one full time professional staff member throughout its existence. It was not a comprehensive mental health center.

The project offered a day care kind of service, home visiting, and crisis service, but it was not in any way an in-patient service program.

The project had a folksy, grass-roots appearance; for example, common in its operation were the use of first names, shirt sleeves, informal furnishings, a fire place used regularly during the winter months, and cubicles rather than large offices for all of the staff. It was not a professional looking operation.

The non-professional trainees were hired because they were a resource to the mental health field. The program was not to meet trainees' needs in any specific way; that is, they were mature, employable citizens without disorganizing problems in their own lives.

The project did not have an exclusive emphasis on either clinical service or community development. It did both. Finally, the project was flexible and evolutionary; it was not static. It was planned around general goals without pre-determined specific techniques. The project was originally a community oriented operation, but it moved in the course of its five year existence from a community oriented operation toward a community owned, generated, developed, and operated group of services. At one point, six specialized areas of services were operational and each had its own unique organizational and administrative structure. The six were: (1) a children's center for emotionally disturbed children; (2) an open door school for retardates; (3) a crisis center service operated 24 hours a day; (4) an adult activities center for socially isolated adults; (5) an alcoholism project; and (6) a juvenile project.

The administrative intent was to gear the atmosphere to the trainees' needs to assist them in becoming proficient and self-actualizing. The individual development of the self was encouraged and there was no attempt to fit every trainee into one pre-conceived model or role. Some of the trainees tended to move toward therapist roles, while others became more adept as coordinators and programs developers.

At times, Liz and I became preoccupied with organizational aspects of this program and, in a sense, lost touch with the trainees. At these times we and the trainees felt the most stress. When we were in touch with the excitement of the trainees and atuned to their needs, many of us who were the professionals of this project found we too were involved in self-actualization.

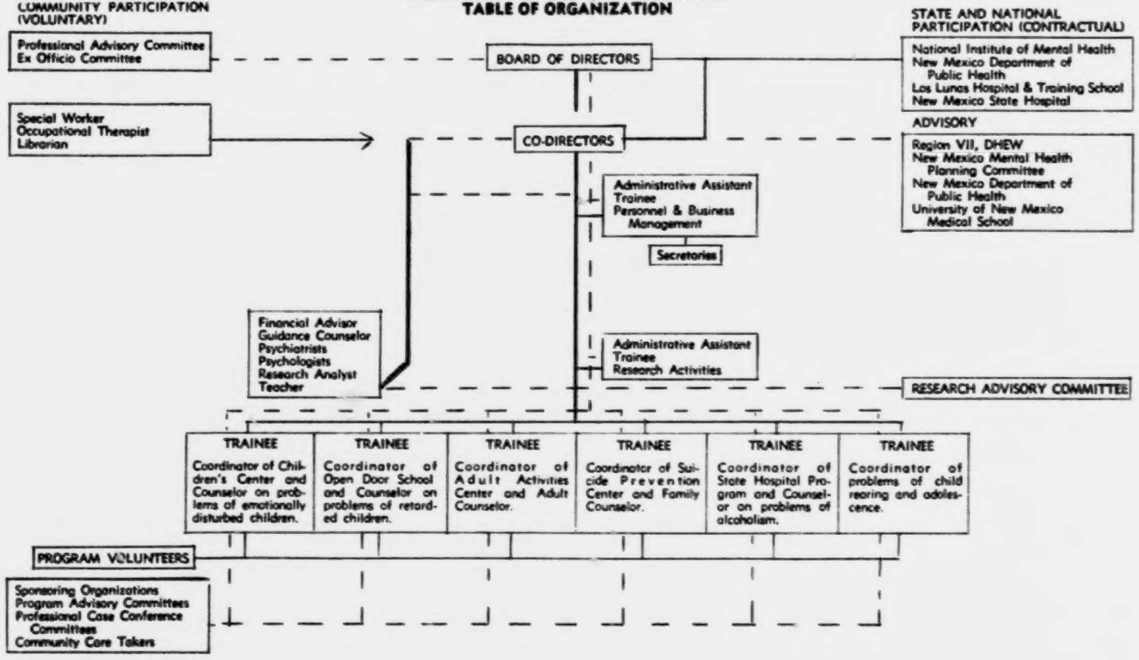
Project Overview

Jan Neleigh and Harriet Pinnock

The purpose of this project overview is to give the big picture. In a later presentation an example of a project, the children's center, will be presented in some detail.

FIGURE I

DONA ANA MENTAL HEALTH SERVICES
TABLE OF ORGANIZATION


COMMUNITY PARTICIPATION (VOLUNTARY)
Professional Advisory Committee
Ex Officio Committee
Special Worker
Occupational Therapist
Librarian
BOARD OF DIRECTORS
CO-DIRECTORS
STATE AND NATIONAL PARTICIPATION (CONTRACTUAL)
National Institute of Mental Health
New Mexico Department of Public Health
Los Lunas Hospital & Training School
New Mexico State Hospital
ADVISORY
Region VII, DHEW
New Mexico Mental Health Planning Committee
New Mexico Department of Public Health
University of New Mexico Medical School
Administrative Assistant
Trainee
Personnel & Business Management
Secretaries
Financial Advisor
Guidance Counselor
Psychiatrists
Psychologists
Research Analyst
Teacher
Administrative Assistant
Trainee
Research Activities
RESEARCH ADVISORY COMMITTEE
TRAINEE
Coordinator of Children's Center and Counselor on problems of emotionally disturbed children.
TRAINEE
Coordinator of Open Door School and Counselor on problems of retarded children.
TRAINEE
Coordinator of Adult Activities Center and Adult Counselor.
TRAINEE
Coordinator of Suicide Prevention Center and Family Counselor.
TRAINEE
Coordinator of State Hospital Program and Counselor on problems of alcoholism.
TRAINEE
Coordinator of problems of child rearing and adolescence.
PROGRAM VOLUNTEERS
Sponsoring Organizations
Program Advisory Committees
Professional Case Conference Committees
Community Care Takers

The Organization

The table of organization, Figure 1, is of the second project year. As we first saw this project, it was headed by a board of directors who were chosen from the community for records of leadership and participation in community affairs. This was a lay board whose chief functions were to set policy and provide liaison with community. The original grant request was signed by the chairman of the board. The present composition of the board of directors is a housewife, a newspaper woman, a vice-president of New Mexico State University, a retired army colonel who is a state senator, a business executive from LTV, a pharmacist-drug store owner, an insurance agent, the owner-manager of a card and party shop and the board chairman who is foreign student advisor at New Mexico State University.

We had an advisory board of professional people. They had no vote on policy matters, but we asked them to participate as much as they could in terms of advice, attitude expression, and attendance at meetings.

We were funded by the National Institute of Health. We originally had some funding from the Department of Public Health. We had contractual arrangements with Los Lunas Hospital and Training School and New Mexico State Hospital for care of some of their clients in the community.

The co-directors of the project were Miss Madore and Dr. William Sears. They had administrative responsibility for the research, training, and service goals of the organization.

The administrative assistant trainee for personnel and business administration was responsible for financial reporting, developing the boards and serving as their executive secretary, training and supervising the secretaries, conducting a screening interview of prospective trainees, handling personnel problems, and at the end of the project, for coordinating preparation of, and submitting a staffing grant request.

The administrative assistant in research was also a trainee.

Note the position of the consultants on the table of organization. As we visualized the consultant role at the beginning of the project, the consultant had no line responsibility or authority, which is usual to consultants. We were selective in choice of consultants, choosing those who were in tune with the basic concepts of the project. The biggest single source of consultants was the University of New Mexico Medical School. Drs. Levy, Senescu, and Libo, who are all here, are from there. Since the project had only one full time professional, and the co-director spent less than one day a week with the project, the interest, involvement, and commitment of the consultants became a very important shaping force. The project director permitted the consultants to give the project what they perceived it needed and what trainees requested rather than what administration dictated.

Some of the project's professional consultants were volunteers. One, a retired social worker, worked through most of the five-year time span, doing home visits with thorough sociological evaluations on every case in which we did a comprehensive evaluation. An occupational therapist offered her services in planning the adult activities center, and was intermittently involved with other projects. A psychologist-statistician trained the research trainee and assisted her with statistical evaluation. A librarian organized and catalogued the library. Others served on advisory committees of the several projects and the parent organization.

The bottom of the table of organization has a group of positions for non-professionals.

The positions are entitled "coordinator," a title descriptive of what we then visualized the trainees should do. They worked with clients and provided the actual day-to-day service of the agency. They were responsible for recruiting volunteers and providing or arranging for the training of these volunteers.

Of the trainees, two were men, 15 were women. Their ages ranged from 32 to 48 when they were hired. Two were married while they were employed, though not to either clients or staff. None of the trainees were native to the area, but most are now permanent residents and non-mobile. In this respect, we tapped a different manpower pool than most university based training programs. The trainees from this project could not go away to get training elsewhere, but are very available here. Trainees' educations ranged from high school to master's level. Their work experience averaged 11.7 years, age, 46 years. The two male trainees had been retired from the army. Five women had jobs of a medical nature, nurses and technicians. One had worked in personnel, four were secretaries, and two had teaching backgrounds. All had children, ranging from pre-school to adult and from one to six per family.

The table of organization shows a direct authority line from the trainee to his program volunteers. These "service volunteers" worked with clients and treatment efforts. They were selectively trained for each project for either group activity leadership or for one-to-one contacts with clients.

As we first conceptualized program development, trainees worked with sponsoring organizations and advisory committees, but not in a direct line position. Originally we thought of the community constituency as a resource. We didn't perhaps credit them with the sophistication with which they might have been credited. They were very helpful in terms of finding volunteers, finding housing, and finding finance, but the trainee and his sponsoring organization on this table of organization are at the bottom of the chart.

The approach to community was altered in the course of the project. Four of the community projects became seperate organizations, each legally incorporated, each functioning under its own board of directors. The Board of Directors of DAMHS served in a capacity of helping DAMHS to fade out. The DAMHS board members served in both advisory and active capacities on the new community project boards, assisting them in getting a firm base for their projects. The DAMHS trainees served as directors and in other capacities in these new organizations. The consultants, who had no line authority on the original table of organization, were seen as co-responsible with the trainees for the direction of the new projects. We started with an idea the community should help us; we ended with an idea we should help the community. The new projects are owned by the community, supported by the community, and administered by the community. The trainees in the latter part of the project truly became community project leaders.

The Community Projects

The **Crisis Center** offers a 24-hour answering service to distressed persons claiming a variety of problems. The re-assuring voice of any one of 28 volunteers offers limited counsel, suggests local resources who may be helpful, or refers the caller to the center's director. The volunteer remains at home while on duty and receives calls from an answering service where the distressed person has left his number. The volunteer returns the call and offers whatever assistance seems appropriate.

Volunteers have been carefully screened by interview to determine their suitability to handle crisis and have received eight hours of lecture on relevant subjects and demonstration of telephone technique. In-service training sessions occur monthly and case handling is discussed.

The Crisis Center is incorporated. A board of directors whose chairman is from the center's sponsoring agency, the Dona Ana County Council of Churches, is composed of four members including an executive secretary who is directly responsible to the center's director. She is a half-time employee whose salary is paid with united fund monies. The center is housed rent free in a local church.

The **Council for Youth, Inc.** is now, essentially, a community project that had its beginning in DAMHS. Urgent need for a temporary residential setting for young boys in trouble gave the community, namely a judge, the Probation Department among others, a single effort on which to expend its energies. Aided by a pledge of $1,000 a month from an out-of-town donor a day-care summer program was initiated.

The council is incorporated, has a 19-member board of directors and a 21-member advisory board. Presently, the service called the "Desert Rascals," has one full time employee, three part time employees and a corps of volunteers some of whom serve as tutors for boys with academic problems. They now feed 22 young fellows nightly and when an emergency arises, they can sleep a few.

Within the structure of DAMHS, a children's center for emotionally disturbed children had been developed and in cooperation with the Dona Ana Association for Retarded Children, the Open Door School facilities were expanded. With the closing of DAMHS, the association for retarded arose to the occasion and, forming a separate governing body, included the fundless children's center in its program. The **Open Door Center** was the product of this action. The director and two full time staff members are former DAMHS trainees.

The Open Door Center now has more than 40 children in attendance at its social and educational facility, which is open five mornings a week. The full time staff are assisted by an educational programmer, three teaching assistants, and about 30 volunteers.

The **Dona Ana County Area Council on Alcoholism** is a new agency, a by-product of the effort to launch an alcoholism program thru a combined community approach. It is incorporated and is governed by a nine-man board. Monies from the united fund will be used to open a facility which, in its beginning at least, will serve as an educational and coordinating center.

The council sponsors the DAMHS-developed alcoholism program which emphasized the use of volunteers as helping persons to clients, and promotes the community in its entirety as a treatment facility.

The Clients

DAMHS handled a steadily increasing client load, ranging from a total client load of 266 during the first year to 784 during the fourth year. During the fourth year 39.7% of the clients (312) were readmitted from previous years, while 472 were first admissions to the facility.

During the first year, more clients were male than female but in succeeding years this trend was reversed. In terms of age, 12.2% of clients were 1-12 years old, 12.2% were 12-20 years old, 45-3% were 20-45 years, and 30.3% were over 45; 33.3% indicated they had had inpatient treatment in some other setting; 38% were from minority groups, primarily Mexican-American. The average adult client had started but did not complete high school.

Referrals were accepted from any source, and no one, regardless of social or economic status or prognosis, was refused service. Major referral sources were: physicians (23.1%), walk-in or sent by family (15.4%), other clients (12.9%), schools (8.9%), welfare (7.7%), clinical agencies (7.3%), law enforcement (6.1%), lay health associations (4.7%).

Disorders of the clients were categorized by functional definition rather than diagnosis. Based on a tally of the third and fourth years, the distribution of client disorders was: emotionally disturbed children, 20.3%; retarded children and adults, 21.8%; suicidal, 14%; situational (reality) disturbances, 43.1%; adult chronic or crisis psychotic and neurotic reactions, 38.8%; adult legal offenders, 1.5%; geriatric, .2%; sexual deviation, 1.1%. The total of more than 100% is explained by the fact many clients existed in multi-problem situations, and each problem was recorded separately.

Over the four year span, trainees did a total of 11,403 individual counseling sessions, and made 5,543 coordination contacts to increase the effectiveness of client care. These figures do not include contacts with clients who were seen every day in any of the day care facilities. As trainees had more experience, they made fewer contacts in the handling of a given client. For example, trainees in the four year span averaged 10.9 contacts per client, but averaged 6.024 contacts per client in the fourth year. Overall, trainees averaged 7 individual counseling sessions per client; in the fourth year, they averaged 3.87. Overall, trainees averaged 3.537 coordination contacts per client; in the fourth year, they averaged 2.307.

Average professional involvements per client during the fourth year were 1.28 per client and 227 of the 784 clients were given professional evaluations.

Fourth year contacts with community concerning clients were 421 with public schools, 392 with clinical agencies, 391 with private physicians, 313 with families and friends, 272 with law enforcement, 185 with welfare, and 116 with ministers.

While the project was not about clients or about programs, both were vehicles through which the trainees demonstrated or reflected the effects of the methods employed in their selection and training.

Client Satisfaction Survey

During the third project year, a sample of clients from the active and inactive files was interviewed for the purpose of evaluating satisfaction of clients handled by non-professionals. A young lady who had a degree in sociology and experience in conducting home interviews was hired to do the survey.

Clients were initially selected from every fifth file from the alphabetical filing system. The interviewer made an initial contact with the client by phone, stating who she was, and requesting an appointment to make a home visit. She identified herself to the clients as doing research on Dona Ana Mental Health Services, not as being from DAMHS. She said she wished to talk with the client about how he liked DAMHS and what he thought of the service. Clients were assured that their comments would be treated with confidentiality; the trainee who handled the case would not see the report of the interview or be told what it said.

Of the 100 Ss selected, the interviewer could locate only 58. The ones she could not locate had actually physically moved; she went to the last address of any client who did not have a phone to personally set up appointments. This is the only concrete evidence of the transient nature of the client population.

The interviewer was granted appointments with all but two subjects. Most seemed willing and in some instances eager to be interviewed. The average interview lasted 50 minutes. The interviewer did not carry a list of questions, and took no notes during the interview.

She scheduled appointments at least two hours apart in order to immediately record the content of the interview.

On two items, the interviewer requested that the subject choose the word which most nearly matched his opinion. To the question, "How did you like DAMHS – the therapist, the atmosphere, the way you were treated?", the subject was asked to specify that the agency was: poor, fair, good, or very good. To the question, "Did you find the service helpful?", subjects were requested to choose: not helpful, little helpful, helpful, or very helpful. The interviewer also asked the client how he was getting along, leading the conversation to the areas of personal functioning, social functioning, and family interaction. Clients' responses to the latter questions were rated by three separate raters on a four point scale: poor, implying worse; fair, holding or slightly improved; good, improved to a point of comfortable functioning; and very good, marked improvement. The raters attained 85% agreement.

Generally speaking, the clients saw DAMHS and its personnel as good to very good; they liked the people. Clients who had been coming for some time, or had been referred or discharged saw the service as very helpful. Those who had very few visits or stopped before discharge indicated that the service had been at least a little helpful. The ratings which raters gave on the different areas of the clients' functioning based on the interview record of how they described their progress-regress were lower generally than any of the clients' ratings of the service. One can speculate that perhaps one is helped if he feels helped, whatever the level of his functioning capacity.

Table 1, which follows, included only 53 subjects. Two of the 58 interviewed appeared for service on a completely erratic basis, and could not be fit into the classification system. Three had been handled only by professional handlers; they were interviewed as an accident of the selection procedure. It is interesting to note that the professional handlers were given the highest and the lowest ratings which were given by the clients in the survey.

Table I
Client Satisfaction

TREATMENT STATUS	CLIENT APPRAISAL OF DAMHS Mean response		RATER APPRAISAL OF CLIENT FUNCTIONING*** Mean rating		
	Personnel*	**Service ****	**Personal**	**Social**	**Family**
INACTIVE					
Stopped before discharge (N=8)	3.12	2.28	2.6	2.3	1.8
Discharged or referred (N=17)	3.70	3.76	3.3	3.1	3.2
ACTIVE					
Very few visits (N=11)	3.63	2.81	2.6	2.5	2.3
Longer term (N=17)	3.88	3.41	2.9	2.5	2.6

* 1, poor; 2, fair; 3, good; 4, very good.

** 1, not helpful; 2, little helpful; 3, helpful; 4, very helpful.

*** 1, poor, implying worse; 2, fair, holding or slightly improved; 3, good, improved to a point of comfortable functioning; 4, very good, markedly improved.

Training Concepts

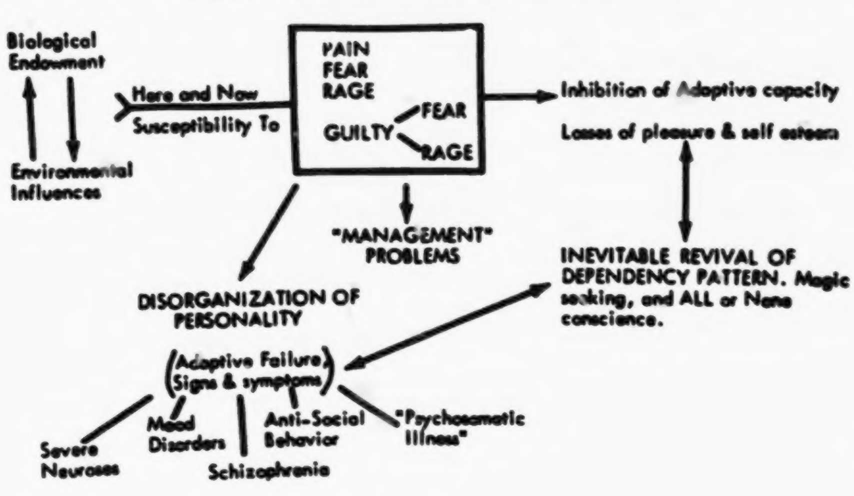
Robert Senescu

In planning for this meeting it was thought it might not be a bad idea to present a few of the principles or concepts important in the training we were privileged to participate in. I would like to show you what we tried to get across.

I can't resist, however, saying two things which are probably apparent to most of you here. First, it became quite apparent to the consultants that the trainees and the various members of the group including board members and citizens of the community, were of a rather high type, for want of a better word, educationally, motivationally, and in terms of capacity to articulate and communicate. Speaking strictly from a pedigogical point of view, they were pretty good students. I think this should not be ignored because it gives one a lot of freedom to plunge in.

Also, I would like to say something about the nature of the consultants. The consultants were unquestionably a pretty polymorphic crew. However, they seemed to have at least one thing in common: they didn't seem to have too great a need to dominate. They didn't dominate at Dona Ana Mental Health Services very obviously, if at all. While there were different points of view among consultants, I think most of them were quite in sympathy with the idea of training the so called non-professional. Some, including myself, feel this is a critical need in medicine across the board, not just in mental health. We have a profound interest in how to establish meaningful rapid communication and provide a kind of dialogue that can result in something which is truly training and education. In some of the debate about how much we can do and cannot do, I tend to be somewhat optimistic. We can do a great deal more than we realize, provided we have the capacity to communicate. This is getting a lot of attention and rightly so.

EMOTIONAL ILLNESS: The Adaptational Point of View.


Biological Endowment
Environmental Influences
Here and Now
Susceptibility To
PAIN
FEAR
RAGE
GUILTY
FEAR
RAGE
Inhibition of Adaptive capacity
Losses of pleasure & self esteem
"MANAGEMENT" PROBLEMS
INEVITABLE REVIVAL OF DEPENDENCY PATTERN. Magic seeking, and ALL or None conscience.
DISORGANIZATION OF PERSONALITY
(Adaptive Failure) (Signs & symptoms)
Severe Neuroses
Mood Disorders
Schizophrenia
Anti-Social Behavior
"Psychosomatic Illness"

Let's get into some of the particular points I tried to convey. The diagram in Figure 11 is global. We label it as emotional illness, in keeping with what actually goes on. We call mental illness an overproduction or an incapacity to handle certain emotional responses, from which you get all kinds of behavioral or social or intellectual or vocational difficulties.

We have found the newcomer in the field lacks confidence in his ability to orient himself to a particular client in a meaningful way in which he can be somewhat helpful, and at least work safely: not hurt either the situation or the individual involved. Some of the people who were seen here were in some rather severe states of disorder. At times there was considerable concern about what to do. Would I be harmful if I said hello? Would I be harmful if I asked a question? Or, would I be harmful if I expressed some interest in what was going on or how it was going on? From an operational point of view, an emotional disorder is a loss of structure. Anything that structures the situation without closing doors and allows people to orient themselves to where they are is extremely useful.

There were several points about the diagram (above) that were very important in our attempts to provide concepts. The first is to distinguish how a person got that way and what is going on at the present time. Put another way, emotional disturbance is in the "here and now." There is no question that why the individual should be susceptible in the here and now is due to past experience or even to constitutional or genetic disorders. But, one of the things we found about these newcomers is they have a wonderful capacity to get lost in the past, to get lost in the developmental aspects of a disorder. Nothing pleases us more than a good history, but nothing displeases us more than having someone avoid the present problem by a preoccupation with biography and developmental phenomenon. So we tended to emphasize certain disorganizing forces we see in the here and now. Put in another way, trouble-makers. The trouble-makers are four in number: pain, fear, rage, and guilt.

By pain here we mean, "How much do you hurt in the business of living?" Obviously, fear is probably one of the most painful emotions. Have you ever been scared? I don't need to tell you its hurts. It's humilitating; it's reductive of self esteem. The only thing more painful is guilty fear. We divide guilt into two categories: guilty fear (I'm bad; I fear I will be punished), and guilty rage (I'm not bad; you are. What's more, you're pickin' on me). One of the more difficult problems we have is this kind of blaming others which can result tragically in attacking in self-defense. (I'm not bad, you are, and I'm going to defend myself.)

The primary job of any helping person is to identify the presence and the intensity of these particular disorganizing elements, and if one is to be helpful, possibly to reduce their intensity. We took as a basic premise that, with all due respect to love and enthusiasm, understanding was probably the most reassuring attitude. Nothing is more reassuring than to demonstrate some understanding and to take away some of the mystery.

To put this in historical perspective, we have developed labels, diagnostic categories. They have some value. Yet the labels tend to pigeon-hole, cubby-hole, get in the way. The people here avoided labels. I tried to suggest the definition of emotional illness in another thousand years is probably going. to be measured in the severity of inhibition: loss of function, pleasure, self-esteem; loss of capacity to adapt, be flexible, learn from experience, live and work in certain areas. Some of these are resultant, some are manifestations, some almost have an etiological aspect to them.

We emphasized pleasure as a necessity, not a luxury. There are pleasure needs just as there are protein, fat, vitamin and carbohydrate needs. We utilized the concept that just as we need food for the maintenance of body integrity, so a certain amount of gratification is necessary. As absence of food can lead to starvation and death, absence of any kind of gratification can make life intolerable. It can lead to a form of starvation we call depression and even death. Putting in a more positive way what the trainees could do, we suggested exploring what the person was trying to do for pleasure was a worthwhile area. If one could encourage a little bit more adventurous attitude some kind of help might result.

Another fundamental fact we tried to get across, one of the basic characteristics of the human being, is he is born more helpless and stays helpless longer than any other being. He is totally dependent on the care, protection and problem solving of others. We presented a rather sophisticated concept, but very understandable, that the trainees should be aware the client would tend to put them in a parent position and would tend to put himself in a child position. The trainee could learn to recognize this and use it for the growth of the individual. He should not fall into the trap of either playing the parent or running away in a tissey from accepting the parent role.

In looking at how behavior is organized, we looked at the pain-pleasure level, the emotional level of organization. Most thinking is an expression of underlying feeling. We have the capacity to be intellectual but in terms of motivation and integration of behavior, it is relatively weak. To call the human being a rational animal is more courteous than accurate. The self learns ways of coping with the world or develops many motivations or integrating elements from his society, his culture, and his constant interaction with this culture. But I think one can spend too much time trying to change the world; the world is not easy to change. While we acknowledge trying to encourage our own particular bias, working with the individual and his emotional reactions or over-reactions might be a more rational and easier way of getting at the problem.

An Example of Project Implementation: Development of A Children's Center

C. Elizabeth Madore, Lee Carpenter, Betty Williams,
Cecilia Tolliver and Lester Libo

Miss Madore: The children's center for emotionally disturbed children was our first community project. The center was designed for children too emotionally disturbed to be in public schools. The concept on which it was built was that meaningful relationships are therapy.

Children admitted to the center were screened by a sophisticated diagnostic process. They were given physical examinations, psychological testing, psychiatric evaluations, sociological evaluations based on home visit techniques, and, finally, admission was determined on the basis of the decision of a community team, a case conference. Most of the diagnostic procedures were provided by private practitioners with arrangements made and paid by parents when possible and by us with such funds as we could arrange otherwise. It was the intention to provide the service other agencies could not, but not substitute for anything which they could provide.

The center was opened with three children. The staff was encouraged to learn to know the clients as children, as people, rather than as cases. The foundation, as intended, was relationships. We attempted to maintain a ratio of one adult for each two children. Volunteers were screened for people who would be warm, accepting and, within limits, permissive. The milieu was to be specifically for these children but as real, as meaningful and as near to normal as possible.

The center was equipped with a great deal of play equipment for both quiet and active group participation. The original program gave the children free access to whatever met their fancy; the aim was to learn to know the needs and interests of the children before any attempt was made to structure the program. The program was originally non-punitive, non-directive milieu therapy.

The program became more structured. In addition to play therapy, group therapy and an educational program were added. Contingency management was introduced as one technique of handling. The concerns, however, were essentially the same: to provide a setting for the children which would promote social, emotional and physical growth and development.

Mrs. Carpenter: Planning for the center was begun in 1962. The most urgent need was to find a place for the center. A barracks at NMSU was offered but rejected because it required costly repairs. The Mesilla Valley Christian Church, whose pastor was alert to community problems, was building a new church and in February 1963, he and his congregation offered the use of four rooms and an extensive playground area. During the six years that the center has enjoyed this setting, the church has tolerated damages to its property and desecration of its gardens and pool by many angry and defiant children.

During the months of planning, before the center actually opened in April 1963, meetings with individuals and groups were held to enlist their support in terms of money (for supplies and equipment, evaluations, scholarships and rent), volunteer help, transportation, and legal advice. The most responsive organizations at that time were the mental health association (which paid the rent for the use of the church), the local chapter of the American Red Cross (which offered volunteers) and the Junior Woman's Club. From this group of young women who contribute their energies and money to several civic projects, came our first cash contribution, used to buy basic materials. Through the years, this club continued its support in the form of scholarships ($15 a month for children whose parents could not afford this fee) and they have shared with the church the cost of fencing the playground. Many of their members have served as some of the best and most faithful volunteers and one of their members has always been on the advisory board of the center.

Other major contributions have been: free transportation by the Whitfield Bus Company; legal advice given by a city attorney; easels, sandbox, dollhouse and puppet theater, all built by the high school woodworking class; sports equipment from local merchants and the athletic department at NMSU and valuable items such as a piano and typewriter from other donors. White Sands Missile Range, through the Officers' and Navy Wives and the Post Engineer, has given us large pieces of playground equipment and yearly scholarships.

On another level, there has been a kind of community support without which the children's center would never have survived: the cooperation of professional individuals and organizations. The Las Cruces School System, the Las Cruces Department of Health and Social Services, local doctors, the staff of McAfee Army Hospital, White Sands Missile Range and the Department of Psychiatry at William Beaumont General Hospital in El Paso have shared records, taken part in conferences and helped the staff work with the families of our children.

One more area of community involvement should be noted: the hours of time and the talents of people who have served on the boards. Early in 1968, anticipating the end of the grant support, it was essential to look for a way to continue operating the center through local funds. The retarded children's association who had been sponsoring and underwriting the program for retarded children, became concerned with continued service to emotionally disturbed children. Some members of the association undertook the responsibility of forming a totally new organization with a new board of directors, designed to sponsor and administer services for children with both mental and emotional handicaps. Thus, in the fall of 1968, the Open Door Center opened as a new program for both retarded and emotionally disturbed children.

Mrs. Williams: As the previous reports have indicated, the children's center was not originally intended to be an educational facility in the traditional sense of the term. Although the children, without exception, were academically below grade level, their primary problems were not perceived as being a lack of school achievement. From its opening in April 1963 until October 1964, the children's center relied upon Las Cruces Public School System to provide homebound instructors for the children enrolled. When the enrollment increased, the public school felt it could not provide additional instructors and thereby prodded DAMHS into the education "business."

The stated goals established at that time were to assist the children in attaining proper grade level for their age groups in order to avoid additional emotional stress upon entering or reentering public school and to teach basic necessary skills for employment and recreation. These goals have not changed. The methods of implementing the goals have undergone several changes.

In October, 1964, DAMHS hired a classroom teacher to teach those children who were not receiving instruction from the public school homebound teachers. She went to the childrens' homes to teach them for one hour two days per week, employing traditional teaching methods.

The children made some academic progress under the home instruction plan. However, the teacher became aware of the vast difference in the childrens' behavior in the home setting where parental discipline was lurking only a wall's width away and the more permissive atmosphere of the center. She felt teaching should also be conducted in an atmosphere that held less restraints for the child, where he could learn to work in the presence of other children if an eventual transfer to public school was to be affective. Also, another child, whose problem centered around separation from his mother, was enrolled at the center. Home instruction was not recommended for him.

For these reasons, in the summer of 1965, the parents were requested to transport their children to the DAMHS office for instruction and the children's class times were overlapped with the teacher giving 1/2 hour individual instruction and 1/2 hour joint instruction. School work was still conducted in the afternoons and, thereby, kept entirely separate from the activities at the children's center.

The fall of 1965 saw three major changes: (1) the staff had had considerable training in the principles of operant conditioning under the direction of Dr. Lloyd Homme and his staff at Westinghouse Research Laboratories located in Albuquerque, (2) a re-appraisal of the academic achievement of the children did not reveal as much progress as had been hoped. It was felt that this was due in part to the small amount of time (two hours per week) devoted to academic studies, and (3) a new coordinator was assigned to the center. These three simultaneous developments lead to the academic program becoming an integral part of the children's center activities.

The center was divided into three areas: social learning area, academic area, and quiet area. All children were scheduled into the academic area for a portion of the morning unless they were judged to be too disturbed to tolerate this much structure. Those children still on public school homebound program were given supplementary material predetermined by a conference between the center teacher and the homebound teacher. Others had a more complete curriculum. Each child was given a contract including all of his assignments for the day. Upon completion of a part of his contract, he was rewarded, for a specified period of time, by the choice of a pictured activity on his individual menu. When this time had elapsed, he returned to the classroom for a repetition of this sequence until his contract was completed, when he returned to the social learning area. This method of integrating work and play was quite effective for the majority of the students most of the time. However, if the child did not willingly come to class when called he was permitted to spend his class time in the quiet area. The quiet room was not intended to be punitive but rather to discourage frequent truancy. (Children could also be directed to the quiet room from the social learning area for the purpose of administering emotional aid or to provide a place to work off hostilities.) There was no reward or punishment in the quiet room — rather a place to explore what conditions or needs made it difficult to participate.

The addition of extra students for classroom activity made necessary the use of programmed materials. Because this method of presentation was relatively new, materials were difficult to locate and it became necessary for the teacher to devise many materials herself. This, plus the fact that the teacher (now called the educational programmer) was simultaneously involved in curriculum planning and material preparation for the Open Door School for retarded children, also under the auspices of DAMHS, made it necessary for DAMHS to add another staff member, a teacher aide, who presented the lessons to the children as prescribed by the educational programmer.

The children's center for emotionally disturbed children and the school for retarded children were combined in the fall of 1968. The development of the educational program for retarded children followed a different pattern than the one described here. Let it suffice that although the programs are different, they are compatible in the same setting.

The academic program is still considered secondary in the overall program for emotionally disturbed children. Its inclusion has, however, enriched the program. The individualized curriculum plus the programmed materials which provide for progress at the pupil's own pace have proved effective. The reward system, now more sophisticated, accentuates success rather than failure and has helped make learning an exciting experience for these children, most of whom are failure-oriented at the time of their admittance to the center. These attitudes have had some carry-over into the social learning area. The educational program remains very basic. Reading, writing and arithmetic are the only subjects offered *per se*. Science, history, geography, music, art, etc. are incorporated into the reading program and provide areas for exploration and expansion in the social learning areas when children indicate interest.

Mrs. Tolliver: Even in its embryonic stage, the plans for the children's center included the participation of volunteers. The American Red Cross Grey Lady volunteers were the first group approached to serve in this capacity. The director of DAMHS, as well as the coordinator, spoke to the group explaining in detail the aims and purposes of the proposed program for emotionally disturbed children, the nature of the illnesses of the possible candidates, and the ways volunteers might be helpful in their therapy. When the children's center opened, the volunteers recruited from this group became actively involved in the program.

From the first day a number of problems became apparent. Some volunteers came with preconceived ideas about the treatment of the children which ran counter to the thinking of the staff; some had little creativity in ways of becoming involved with the children; some had apparently come for a social visit and spent too much time visiting with other volunteers; the prescribed uniforms were too restricting for some of the chosen activities of the children. To combat these and other problems, daily conferences were held at the end of each morning's program. A deeper understanding of the program's implications resulted in some volunteers deciding this was not their "cup of tea." Others found the program so stimulating they remained as volunteers for years and one from this group became a member of the DAMHS staff. From the beginning, volunteers became an integral part of the program. As the enrollment increased, more volunteers were solicited from civic groups, social groups, churches, university students and other interested individuals. The recruiting was done by staff members who spoke at group meetings, were interviewed on the radio, and by personal contact of staff and other volunteers. Gradually, the community became aware of the existence and needs of this group of special children.

The original plan of orienting potential volunteers was supplemented by an observation period at the center, to see the program in action, before a commitment was made to serve. The need for confidentiality was stressed. As the need was indicated in the early phases, almost daily informal meetings of volunteers and the coordinator were continued. In addition to these impromptu meetings, training for volunteers was given at monthly volunteer meetings where common problems were discussed; lectures and films were presented. Volunteers were occasionally invited to attend staff in-service training sessions. Not until this year was a formal volunteer training course offered.

Some volunteers who found work with the children did not satisfy their needs were directed to other services offered by DAMHS where volunteers were needed or were used in other ways such as providing transportation, interpreting during interviews and case conferences, making home visits, baby sitting and making materials to be used at the center or accompanying on field trips.

In order for volunteers to be most effective, it was found that they should attend regularly at least one day a week; some worked two or three days a week. They should have a positive attitude regarding the children, the program and the staff. They should be secure enough personally to tolerate unconventional behavior and seek causes rather than be judgmental. The coordinator, in order to maintain the volunteer staff, must be sensitive to the needs of the volunteer and willing to be supportive at times of discouragement.

Incorporating the center for emotionally disturbed children and the school for retardates and housing them in a common location has been beneficial in maintaining volunteers who have felt uncomfortable working with one or the other type of children. For those who need structure and to know precisely what they are to do, though progress is slow, more satisfaction is derived from being involved with the retarded children.

As the services and methods of the center became better known in the community, other groups recognized it as being a valuable training ground for their personnel. The school of practical nursing requested orientation for its students. They were required to observe and encouraged to become involved with the children at the center for at least two days The Guidance Department at New Mexico State University sent several practicuum students to the center for laboratory experience. Professors of education, psychology and physical education frequently made observation of the center mandatory and encouraged their students to volunteer.

Other than working with the children themselves, several professional people have assisted at the center. A retired social worker and a psychologist made home visits to obtain social histories. Public school and university personnel have assisted in program development and volunteer training. Physicians, dentists, nurses, psychologists, psychiatrists, lawyers, accountants and others have been called on intermittently and most have gladly given assistance.

The premise that volunteers could be a valuable part of the children's center program was correct. It is not predicted that their contribution could be replaced by additional staff members. Their eagerness to learn keeps the staff from becoming stagnant in their approach to the problems, renews their enthusiasm and forces them to become aware of new developments in the field.

Dr. Libo: Listening to the description of the children's center was a funny experience. I was the consultant to the center almost from the beginning and yet I feel I was more of a tourist and learner than I was a director of a program. Things on the whole took their course; the program was in good hands. I'd come around once a month from Albuquerque, play with the kids, compliment the staff and sometimes demonstrate some things. Sometimes I'd feel sleepy, feeling I didn't have anything to do. Sometimes I was bored, because it was such a laborious process. I've been coming for about four years; I saw all these kids at the beginning, at their worst. It's only after about four years you see some of the kids are back in school, some are talking, some are relating.

The first experience I had in the center was being met by two very anxious motherly people, both trainees, both in charge of the program. I felt both were pretty much at a loss. I was asked to step into the situation, though I'm not a children's expert. I'd had one year of experience in a child guidance clinic with none in a residential or day treatment center, so we had two trainees and a consultant all at a loss. The feeling was overwhelming in a way. In those days, I feel I was much more rigid than I am now, and I said, "We've got to get some structure into this." Liz's philosophy was not to have much structure, to have it very permissive, so that someday, somehow the love would sink in and a structure would emerge.

Fortunately, after several months, we found the field of reinforcement learning theory and contingency management, largely from the Albuquerque group at Westinghouse. They came in and did supervision, demonstration and teaching, and we carried it out. Physically, in the contingency management model, there are always two rooms involved. There is a high probability behavior area. This is the social learning room, in which there are toys, a piano, various games, and refreshments. High probability behavior would be pleasurable behavior, play. The low probability behavior is the task area, the little school next to it. School work is reinforced immediately in the play area.

Another thing introduced was a token economy. The staff members had tokens or chips, which they gave the child any time he emitted the kind of behavior considered desirable, any kind of behavior having to do with verbalization for the non-verbal kid, or relating, or cooperating. We've done this playing croquet, volley ball, walking, running, playing with Lincoln logs; whenever it occurs, be ready with a chip.

Friday is store day. There is a display cabinet with all kinds of goodies from candy to models to dolls. The kids each have their container with their chips for the week which they used to buy what they want. This system was not held very rigorously, which was one thing I felt was a disadvantage of once a month consultation. When I came, I would try to get it back in the swing of things, but between I thought there were often inconsistencies. People didn't give chips, didn't have them, or used other means like gold stars and silver stars, which I don't think are as effective. But in a situation with very disturbed kids, things do tend to be chaotic. There is a lot of anxiety on the part of staff. Any kind of structure, any kind of model you believe in is apt to help make the atmosphere more one of self confidence. I found the contingency management model a very convenient handle to give some structure.

On a day to day basis, work with the children was laborious, very slow, almost person to person housekeeping. "Put up the crayons." "It's time for school." But as you look back on it, you see that one boy who was playing a psychotic Maginot Line game with me four years ago, now relates very well and can conduct a sane conversation. Another boy did not talk at all, never looked at you. Now he talks, relates, compliments other people, walks up and shakes your hand and looks you in the eye. One little boy was so wild and destructive we spent most of our time running after him, trying to get him into some kind of a self-controlling or environmentally controlling situation. He is back in school and doing well. A little girl, also quite wild and tormented, is much happier and also back in school.

On the monthly trip, I would spend maybe three hours in the morning in the children's center. In the afternoon, if we had a difficult case, we might have a case conference bringing in all the relevant community agency people. Or, I would do family interviews with adult clients and children, or drawings with kids, or diagnostic play. But I was never a clinical consultant to whom they would refer a client and get a report. One principle I always held to was that I would not do anything in the program without having a trainee present. Even in the children's center, if the trainees wanted me to talk to a kid they were concerned with, we'd get off in a corner in the large social learning activity room. There would always be a trainee or volunteer or graduate student present so they could learn from the consultant. Otherwise it would be a very distant kind of service, coming down once a month from two hundred fifty miles away. It would be like the traveling team, doing their job and not leaving anything sustaining. We felt the thing we could leave which was sustaining was the skill incorporated within the trainee.

I'd like to give you a few more impressions of what it felt like to be a consultant, mainly in the children's area, though all of the consultants worked some time in all of the components. One of the joys of working as a consultant in a setting like this is they really listen to you. They're like little birds. They apply everything, almost indiscriminately. You have to be very careful about what you advise, because they will do it; they'll try it. We've tried many things, and we've looked up many things together. We got involved in developmental schedules; we got involved in autism, in play therapy, in reinforcement therapy, etc. It was more of an educational experience I think for a consultant than it was one of giving a lot of structured consultation to the trainees.

There were four sets of coordinators during my tenure as consultant, and I think the anxiety level gradually went down with each successive coordinator. I think the place shaped up. I would say in the last year and a half it looked as good as any you would see anywhere. The people act and talk like they know what they are doing in the structured program and in the free play therapeutic program. If a visitor were to come not knowing these were non-traditional workers, I think they would not guess they were. The coordinators act like children's center therapists. The teachers are more skilled than mental health professionals would be with such kids.

One of the biggest functions I thought the consultant performed was to give the staff members a feeling of support and security. Liz was very antsy selecting consultants. She wanted to be sure there wouldn't be anyone in the system who would be overly critical, and I watched myself very carefully on this. I wanted to make the grade; I felt it would be an honor. As it turned out, it was very difficult to be critical; things really went very well. The trainees didn't do things necessarily the way we would do them. For example, since I couldn't keep track of the kids at first, I asked the trainee to prepare a little resume of the kids that I could keep. Well, they didn't put the chief complaint first; they'd put the history first. Little by little, we brainwashed each other and got to do things each others' way. Another example is being on a first name basis. At first I was a little uncomfortable about being introduced to community people by my first name. As I look back at this now, I think it was ridiculous and a little immature of me to react that way, because I do think the atmosphere was very therapeutic because of its folksiness. Right now professional labels are just not that important to me.

In conclusion, it's a reappraisal that's not agonizing but rather pleasureable, because when I look back on it, I don't see that I did anything. I sometimes wondered if I had enough to offer them. At times I just sat back and watched and said, "Fine, you're doing fine," and maybe this is mainly what gifted non-traditional trainees need. They need the sanction of the professional. They need to feel they are being backed up, that you're back there somewhere, and we were.

It really was a well organized program that made the visitor feel good about it. When you look back, you see that all the kids seem to have done very well.

Impact of The Project on Community And State

Panel members:

William Sears, Robert Senescu, William Shelton, Alice Gruver,
Margaret Day, Pat Johnson, Judy Nixon and Mike Neal

Dr. Sears: I have an urge to back off and listen; I'd like to pass the buck to Dr. Senescu. Bob, why don't you discuss what this had tickled with you in the way of ideas or thoughts about implications for the state from the point of view of the medical school?

Dr. Senescu: I had a lot of thoughts about this during the group meeting and after it. I think that to understand this project is a lesson in history in the sense of how much has happened in this country in the last five years. It's incredible – the change in attitudes, the sets, the kinds of tactics, the maneuvers. Specifically the question in many minds is social action, and the question of what the function of any group is that is involved in building up any kind of mental health facility. It's important to remember, I think, the goal when this project was conceived was to train the non-professionals. To put it another way, it was a very early attempt to make use of the vast reservoir of wasted talent in this country, and particularly in New Mexico, in an effort to meet the grossly neglected straight-forward psychiatric needs of the community. The idea on the one hand of trying to provide services for people who had absolutely zero and to tap the wasted talent or the available sources of skilled people was a very sensible as well as a somewhat radical notion. I don't think there is any question that both principles are as sound as they ever were. I could not conceive of how a mental health center in any form would be possible in this community without having had the presence of the Dona Ana Mental Health center. I think its existence played a great role in persuading, convincing and demonstrating to the community that such services were needed, useful and made a contribution to the community on a variety of levels. We are seeing a fruition of this project which I don't think was expected by the group when it started, and yet I think has evolved quite naturally.

I am somewhat biased myself. I don't think I needed much documentation that we had to or could or should make better use of wasted talent. I would regard it almost as routine in the sense that there would be no argument, to encourage in any possible way the creation of more Carpenter, Williams, Neleigh, Pinnock, and King types to float around the state. If anything, I would be inclined to say that these people still could do more, much more. I think they have been very correctly cautious in this development period. They have kept themselves in a remarkably sound state of restraint in terms of involvement. They have provided a sound basis to proceed along the same lines and perhaps reach out into areas that have been relatively neglected thus far.

Mrs. Gruver: If I may digress just a little bit from a topic that was assigned, could I take a couple of minutes to go into the history of all this before going into the impact? It was something like 12 years ago, that I traveled with a group of American Association of University Women from Las Cruces to a statewide conference, and there heard two very brash young damn-yankees tell us we have the two platoon system in running our state hospital. While I recognized the truth of what they said, I was a bit prone to resent it as a native-born New Mexican. But as the conference progressed and they saw this area as something new, and innovations were described, it challenged us. We came back to Las Cruces. We had been told that we would not get any portion of the mental health program being started in the state, because we had no background, no framework. We didn't even have a mental health association. We expected the professional services would go to Roswell, which was a little more sophisticated than we were. We got to work, formed a steering committee, scrounged a hundred dollars from the women's club, and went to the county commissioners.

The man who was chairman was totally against all this. He told us he did not believe we should be spending taxpayers' money bringing in new programs here. He spoke against it, but he went along with it.

Well, we got the mental health association started, Liz came here and the mental health services was born. I have a picture in my mind something like a goldfish bowl with these trainees and their resources sort of swimming around in this bowl. Those of us who are on the lay staff were outside looking in. Of course, the dark side was the trainees. Because of the necessity for confidentiality of clients, we couldn't know what was happening there. I personally had confidence in what Miss Madore and Dr. Sears were doing. I felt they were professional people, people of integrity, who had shown they were willing to work twenty-four hours a day. With that degree of confidence, we stayed with the program until the time last October when the bowl was broken and the fish swam out into the current.

I don't know how much national or international impact this program will have. This has to be a subjective thing with me. How do you measure the impact? I think it is you people who are going to take away the concepts, the philosophy, the workability of the program who will determine what impact it will have in time to come. I don't say it will come about tomorrow, but I think the impact of this program is beyond measure.

Dr. Shelton: I'd like to address myself to just one phase of impact, that is the impact of Dona Ana Mental Health Services on the new mental health center. The new mental health center was really generated by the Dona Ana Mental Health Services, and the philosophy of the Dona Ana Mental Health Services was one in which non-professionals were used where professional shortages existed. The new mental health center is different in that it will involve professionals. What does this mean in terms of the non-professionals who are already here? Something brought out yesterday is that one of the biggest differences between the professionals and the non-professionals is that the professionals know there are no answers to a lot of questions about mental health. Professionals can skillfully hide this knowledge quite often. Does a new center beginning mean to the non-professionals that they are like troops on the front line who will get a rest now that reinforcements with more equipment are arriving? Will the professional reinforcements serve to stifle future growth and new ideas? I hope not. The new center will be obligated to serve a larger area which actually opens the door for expansion into these new areas along lines similar to those used by the Dona Ana Mental Health Services to provide service to Dona Ana County.

In terms of measuring impact, I think there is a way of measuring it, although it is not too tangible. Ten or 20 years from now the impact will be felt in lower incidence of serious mental illness, crime, alcoholism, drug addiction, divorce, poverty, school drop outs, suicide, and homicide.

Dr. Sears: Margaret, you have been able to watch what's happened in Las Cruces over the life of this project with interest and effort which has been very sustained in terms of the children's aspect of the program. You were doing some things for the retarded before Dona Ana Mental Health Services. I wonder if you could share a little bit of how the impact looked from your point of view?

Mrs. Day: Well, we now have a real school. Before Dona Ana Mental Health Services took over, we had something better than nothing, but it was baby-sitting, really. The only time we ever had a teacher with any formal training we kept her only about three months. That was when the board of the retarded children's association realized what could be done for retarded children in the community who were not eligible for public school. When we joined forces with Dona Ana Mental Health Services we had quite a few battles in our board, because some people felt this should be a project of the retarded association only, but there were enough of us who were delighted to get help.

Our school has had tremendous support from the community. We are now a united fund agency. The school is separate from the retarded association now; it has a board of directors of its own.

We expanded this year to include the emotionally disturbed children from the children's center because they had no sponsor after Dona Ana Mental Health Services ended their project. It's a much larger school now. It's very well known throughout the community and everyone feels that the children really are being prepared. The younger ones are being prepared for public school, the ones who are capable; at least they will have the opportunity to be able to get into public school.

Mrs. Johnson: Yesterday, Les said he felt like the old grandfather when he talked about this program. Well he might, because he is actually the grandfather of our state hospital field program as well. He mentioned that when he first came to the state of New Mexico, he had two field workers who were covering the whole state. As a result of the Dona Ana program and the other programs initiated at the time, we now have 11 field offices. 14 field workers, and 12 of these field workers are the non-professional type. Maybe there is something to the bumble-bee theory: if you don't know you can't fly, you fly. Our workers are not only involved in direct services, but in indirect services and community development. We do much borrowing from this idea of volunteers, not only building volunteer organizations in communities, but using volunteers on a one-to-one basis with patients. We start with a patient. In some communities in New Mexico which have only three or four families, you are obviously not going to have a mental health program as such; but you can build a mental health program around one patient by involving neighbors or the general store keeper or whoever is there. We have employed the whole idea of using the untrained worker to get into the community, using people who live in the communities, know their communities and are accepted there. The approach has tremendous impact, I feel.

Miss Nixon: I think one of the main impacts of this project statewide has been that it gives other communities hope of doing something. I think in New Mexico in the past people thought, "Oh, well, we can't do anything, because we don't have a professional staff." I think other communities are looking closely at Las Cruces, and thinking, "How did all this happen? How can they do that? How can we develop something in our own communities like this?"

One of the main values statewide has been that it has shown that it can be done with non-professionals. (I dislike the term non-professional or non-trained. I don't think this is at all valid; non-traditional might be more appropriate.) But communities are beginning to wake up to the fact they can do something. Perhaps with a few individuals in each community to begin to get the ball rolling, we can begin to develop resources in scattered isolated areas that previously had none.

Dr. Neal: I'd like to speak as a late comer on the scene who hopes to reap a great deal of benefit from all that has gone before. To me, the things that have gone on and are going on here in Las Cruces are some of the most exciting developments I have seen in the whole field of community mental health in the country. I think this is very exciting because too often what have been called community mental health programs are really situations where somebody conned the feds on the state into sending a pack of money into a community, and set up what is really a small state hospital geographically located in a high population density. Because of this, it gets called a community mental health center, and it isn't. It may have started with a great deal of community enthusiasm, but as soon as state and federal governments take over, a program is no longer an organized part of the life of the community. All the people who have worked hard relax, and say, "Now they are going to take over and we don't have to work anymore." It is no longer a community mental health center.

To me, the exciting thing about Las Cruces is not only that it has evolved from the demands of the community and the specific kinds of needs of the community, but also the new program which has just stepped in is still almost entirely community based. This is going to be a rocky road ahead, but the community has accepted a level of responsibility which I have seldom seen in community mental health programs anywhere. At the state level, we are very excited about this. We hope this is going to be a model which other people can come and look at to get ideas about how they can tailor programs to their communities, not necessarily in the Las Cruces model, but in a way that will meet their particular problems.

Col. Russell: In terms of impact, you never know where these things will lead. I was responsible for teaching a two hour block on preventive psychiatry to all the medical department officers coming to the medical field service school at Fort Sam Houston for three years. Since they had just come from civilian life, in order to discuss preventive psychiatry and how it applies to the military, the example I used was Las Cruces and Liz's program.

Dr. Reiff: I wonder if there are any plans on the drawing board now for any programs in the state of New Mexico which plan to utilize the experience of the Dona Ana Mental Health Services?

Dr. Neal: I would like to answer that in reverse; we have plans to use the Dona Ana Mental Health Service. The question of how you broaden the recruitment base for health workers has occupied a lot of people including the people here in Las Cruces. This has to be applied on a larger scale to larger systems. Unfortunately, one of the problems when you start approaching a larger system is, it is already pretty well entrenched in its own kind of bureaucracy and people say it's impossible to make these kinds of changes. We have on our departmental drawing board a new approach to personnel classification and hiring which is an attempt to give people entry into our system from all levels of background and experience. Perhaps we will use the center as a testing ground for some of the new approaches which have to be formalized on paper and engraved in punch cards and computer tape to help us get our personnel classification off the ground.

Dr. Shelton: My biggest fear in starting the Southwest Mental Health Center is the danger that the new center with the professionals coming in might stifle what has been going on. This is why I am being very selective about people for the new center.

Mr. Boucher: How do you perceive the role of the professional in the new mental health center? What will they do? I would assume they would do something different than if they went to certain other mental health centers.

Dr. Shelton: There's nothing like being asked to formulate your ideas one week after opening! I don't know if it is a question of what they are going to do so much as what their personality is, how well they are going to be able to use ideas they have, be able to set up an atmosphere where what has been developed will continue to develop. Does that answer your question?

Mr. Boucher: Yes. You see, I think one could ask the same general question of all professionals. What will the professional of the 1970's do? Because clearly he will not do the things he did in the 1950's and 1960's. It seems to me the question will not be answered very well by any of the more traditional and therefore more hide-bound mental health services in many parts of the country; it will be answered, if it is answered at all rationally, by centers such as this one. I think the question is a very crucial one to the rest of the West and much of the rest of the country.

Dr. Libo: I think one thing which has not been considered is the possible squelching effect on the professional coming into such an awe-inspiring program with people who have been around in the community. The professional is going to be so dependent on people who have been here, how will he be able to fulfill himself? What if he feels caged and can't really fly?

Dr. Shelton: Let me mention one thing in this regard; tradition has already been established here, I feel. Are we hidebound to that tradition, or can new traditions be established? I think that everyone should participate in a kind of expanding of horizons, moving forward.

Dr. Reiff: I would like to make a distinction. I don't think this has been a training program of non-professionals; this has really been a training program of non-credentialed professionals. I think that distinction is important, and will have implications toward its applicability. There are a number of other programs that have been training non-credentialed professionals. The model is a very simple model, and very different from the non-professional model. The model is the Industrial model. During the second world war when it became necessary to train a great many workers in plants throughout the country to do skilled labor, the skilled labor job was broken up into various parts and people were trained to do certain parts of the skilled labor. There was some resistance from the skilled labor people to breaking up their jobs this way, but at the same time there was obviously a very important need in the country and they went along with it. I think the need for non-credentialed professionals is in the human services as it was in the industrial plants in the country. But it is a different model than it usually the model for training non-professionals. It seems to me its innovative aspects are not innovative in terms of the nature of the services one gives; its innovation is in a delivery system.

At the same time, the community mental health center is supposed to be an innovation in delivery systems. It seems to me, therefore, there ought to be some kind of an integration of this kind of model with the community mental health centers in the country, because they both are innovations in the systems of delivery of care. Thinking of the areas where these two innovations meet would be an important way of attaching the problem of how this innovation can be applied throughout the country.

Dr. Routt: Are you implying that you should only make plans for linking the non-credentialed professionals and the community mental health center or do you think there should also be plans for linking the non-professional and the mental health centers?

Dr. Reiff: No, I did not imply that only non-credentialed professionals be linked with the community mental health center, but linking the non-professional and the community mental health center is not only an innovation in delivery systems. It is an innovation in the substantive nature of the care giver, so it is a different problem.

Mr. Ontiveros: Let me ask the panel if they feel the real non-professionals – the Indian, the Chicano, the black, middle income, upper incomes, non-high school grads – could have done what these trainees did?

Mrs. Johnson: I think we are seeing it done in the Navaho alcoholism program, for example.

Dr. Senescu: I would say yes to that. I think the program might have had to be a little different from this one, but we're seeing signs in Bernalillo County where the responsivity of some of these people is just remarkable, in terms of their grasp, their understanding, their capacity. The esoterica of 20 years ago is the common place of today. I think the question about how the professional is to be used 20 years from now is being ignored. The implication is that he is going to have to know a lot more than he knows now. He is going to have to be even more of a technician, but a different kind of a technician. He is going to have to be much of a teacher, backer-upper, an individual who doesn't get in the way, but is there all the time. He is going to have to be a constant evaluator, fast on his feet, and know an awful lot. The professional has to allow the mold to take on more flexible and realistic forms if he is to have any use at all.

Dr. Libo: I think there is one characteristic of communities like these in New Mexico that should be kept in mind. If you talk about non-traditional programs in Boston or New York or Los Angeles, you don't have as much of an initial battle of having to sell the power structure on the very basic assumptions about needing to have **some** services. Maybe you do, but there is a difference. Would you grant us the assumption that the bankers and the lawyers and the high society of the community in states like ours had not bought and have not been involved in these programs as much as they have in the large cities? Then one element in states like ours, and particularly in smaller communities, is that there is a need to make these kinds of human service programs respectable in the eyes of the money and power, while also involving the poor and the consumer. I'm not sure if we had started here with a program staffed by the poor, it would have worked. As long as nurses and welfare workers were asking for these programs, they never got them, but as soon as the power elite started asking for them, all this changed. We never had a Mrs. Rockefeller in New Mexico.

Dr. Reiff: I spent seven years trying to develop health programs among the labor unions, and I wanted to develop innovative programs. The program really was unsuccessful because people in the labor unions said, "We don't want new and innovative programs; if it's good enough for Rockefeller, it's good enough for us." I want to raise a question, though, to present a way of thinking about this problem, which may give you some insight into development of the program, or future development of the program. What you are really saying is, you chose the established power structure to become a constituency of yours to fight for mental health. That was your strategy, and in a sense it determined the nature of your program. Now, there is another strategy that has been used in some of these other areas, the strategy that makes the people in the community the constituency, and advances a totally different kind of program. The nature of your program really does and should depend on who you decide your constituency will be. You have made the decision and I don't think I or anybody has a right to say it is not a correct decision, but in thinking about the future one should think about whether to continue with this strategy, whether it's necessary. You may have no choice but to continue with the strategy of making your constituency the power structure. On the other hand, there is the alternative that you may go directly to the community.

One of the problems in reading the documents is that the same words mean totally different things to different people. When you talk about community participation in the papers, the words have a totally different meaning to me than to the people here at this conference. The reason is that community participation is a way of referring to your constituency. You are talking about the power structure when you talk about community participation, and I'm talking about the people in the community.

Dr. Libo: You aren't talking only about consumers of the service?

Dr. Reiff: I am not talking about the schizophrenics in the community; I am talking about the residents of the community who are potential consumers.

Dr. Libo: The problem is, if people define mental health more narrowly than it is defined in the social action programs, you have a different definition of constituency. If you define mental health in terms of total health, education and welfare, you can work with the whole community. But, if you are talking only about mental health, the translation becomes mental illness; this defines the function of mental health professionals and mental health facilities as treatment of the sick. This is a much narrower definition and your constituency narrows.

Dr. Senescu: I don't think there is any contradiction here. It has been ten years since this program was conceived. The very neighborhood centers which three or four years ago would say to us, "Tell us what we should do," now with a great deal of independence and pride say, "Don't turn us into another agency; we have work to do!" But they did not have the identity here ten years ago, and I'm not so sure they had as much in other areas of the country as they have had in the last five years. You have groups to deal with now you never had to deal with. I think this is more marked in New Mexico, perhaps, than elsewhere. The militancy, assertiveness, group cohesion, or the pride is just beginning to take form. This does create the possibility of other strategies which were non-existent; I think this underlines your point very well.

Dr. Cumings: It seems to me what you have done is to loosen up and humanize the system. Until we began to look at systems, we were pretty hierarchic and structured and pretty much assembly line in the delivery of service *per se*. When we opened up and began to look at systems, we opened Pandora's box, but I think it is a very healthy box. I think what I've seen happening here in terms of community effort is part of the whole movement and transition we are seeking to effect today. The loosening of the professional system had a similar effect on the community systems with a degree of freedom to grow their own programs. I think it ties into the discussion of roles for professionals in the 1980's. When you look at what is going on on campuses and the demands to make changes in that kind of an institutionalized system, I think you are very healthy.

Applicability and Generalizability

Panel: Moderator, Robert Reiff; Members, Stan Boucher, Earl Staton, and James Moncrief

Dr. Reiff: Somebody once asked for a definition of a professional, and the answer was, "Well, a quack is one who is respected by his clients; a professional is one who is respected by his colleagues." I do not mean to imply that non-professionals are quacks.

This panel is supposed to stimulate a discussion on what we see as valuable and usable in our own programs. As a matter of beginning discussion, I hope it can be informal – please feel free to interrupt at any point to ask a question, or to tell us where to get off, or to call us damn yankees, or anything else you care to. Perhaps you would like to start, Mr. Staton.

Mr. Staton: As the panel's primary purpose is to react to proceedings of the last two days and to respond to the project's implications for our programs, it would be well to give you a background of my program. The Kentucky Mental Health Manpower Commission is a personnel research and demonstration program which you could say is very similar to a small WICHE or a small SREB in that we are funded through grants and contracts from federal, private and state sources. We devote our entire attention to research in the field of mental health manpower. We have been working for about two years in designing and developing what we call a community mental health worker project. It has been submitted to NIMH which has approved the grant request provisionally, pending the availability of funds. This is the specific reason I am here. Hopefully, I have found some things which I can use in implementing my specific project.

Before reacting, I should qualify my remarks and comments. It is very easy to sit outside and take potshots at something that has been going on for five years, and I do not mean to be disrespectful or derrogatory. However, as our purpose is to react honestly, let me share a few of my immediate thoughts.

I think first of all the screening process, the selection procedure and the evaluation criteria which you have developed and utilized should be of particular help. My project proposes to train three levels of community mental health workers; we are thinking of an aide level, a technician level which will be a two year product, and a representative or four year product. We envision training and placing all three of these in a center where they will perform assigned duties. After evaluation, we will be able to demonstrate the advantages and disadvantages of each. Therefore, your selection criteria and your evaluation techniques are somethings which should be of particular value to us and are items on which I hope we will be able to obtain more data.

The area in which I am left somewhat confused or wanting is the question of how applicable your project is to other programs in states which have progressed beyond the point of the frontier approach described in starting the presentation yesterday morning. I am sure there are areas where this can be replicated in a fashion very similar to what has been described, but I am somewhat concerned when you get into an area where programs are already established and operating. My state has 15 community mental health centers, 13 of them already staffed. If I were to go to them and say, "Let's develop some new levels of mental health workers," and they say, "All right. What are going to be the roles?" And I'll say, "Well, let's train them to do their thing," I'm afraid I won't get very far. If they come back and say, "What kind of training program are you going to set up?", I'll say, "Well, we'll develop it as we go along," I'd get the same reaction. What I'm looking for is more structured role identification, assignment of duties, responsibilities, training curriculum and evaluation of work performance. These are some of the problems or areas that have concerned me in the last two days. I think I could go into the very rural and under-developed areas of Appalachia such as Wolf or Bell counties and apply various aspects of the project. However, when 105 to 110 of the 120 counties of Kentucky already have some kind of a structured mental health program or service, my problem becomes one of drawing together the professionals to a point they will agree there are some things which others with less training can perform and some duties they can give up. To me, these are the major problems I see in adapting results of your project.

Mr. Moncrief: Basically, what I am now involved in in the State of North Carolina is a three-way appointment. I am working with the state department of mental health, the state personnel department, and the Board of Higher Education of North Carolina. What we are doing in the state is to set up career ladders for the mental health worker and also the social welfare worker, beginning with the in-service training and up-grading of the technicians in our state hospitals and clinics. That is, taking the aide and giving him some type of collegiate training and making a better worker of him. Secondly, we are working through the community college system, setting up curriculum for the two-year mental health technician. On a third level, the baccalaureate level, we are training a mental health technology and social welfare worker. This is being done in conjunction with three of the major universities in North Carolina currently. Our fourth level of worker is our master's level mental health administrator. We will run a pilot project in this at East Carolina University in Greenville.

Prior to going with the State Department of Mental Health of North Carolina, I was with the Southern Regional Education Board, working on the project promotion of the community college mental health worker. On this project I had contact with the 15 Southern states plus the nation as a whole, since we were working under a NIMH grant.

One of the things I looked at here in this program, and basically what we can use in our program in North Carolina and can recommend to SREB is the selection process and the research evaluation. This could be adapted to the 15 Southern states and also specifically to the state of North Carolina, not only to the two year program, but to the four year program as well. Frankly, I feel the selection process would be better utilized in our baccalaureate level, working toward the B.A. degree rather than toward the associate degree, because those of you who were trained here were trained at a much higher level than the two-year worker, and you certainly should be classified in some degree as professionals.

But we have the same hang-ups, the same problems that Earl Staton mentioned. The type worker you have trained here would not, we feel, fit into our particular scheme. We have areas in North Carolina on the outer banks which have no developmental programs now, and a worker of this type would fit nicely in that system. There are some sections in the state of Alabama where this type program would be usable. But, we feel it would have to be in what you point out here is a frontier area, a completely under-developed area as far as mental health is concerned.

Another problem I see at this point is that we see no specific training goals which you have been given — no common goals, no common scheme; you were trained in specific areas, each one. Working for the state personnel department we have to confront reality here, because we are tied up with a merit system. We are also tied up with structuring new jobs for the mental health workers; a whole concept of job analysis is changing in the state of North Carolina. We are going back to write up new job descriptions for the mental health worker. If I went back and attempted to write up four or five different job descriptions for each one of the basic jobs you are performing, we would get into a state of utter chaos, because we would have to write each job completely. There would be no generalized job description, and this is needed, facing budgetary reality.

I love innovation; I am not trying to put you down, so to speak, as far as your enthusiasm and your frontier drive. But we have to face reality. We are dealing with state legislature; we are dealing with county commissioners. We do have to have more of a goal, role description, job description, of what you are being trained for — not specifics now, but some generalized curriculum, — so we know what you have been trained to do.

The mystique of the worker trained here is a problem we are confronted with now. I would like to know what you were trained to do. I would like to know your training program. You had some training. You had your consultants. What specifically did they do for you? What specific training activities were you engaged in? We know nothing of this at this point, except you were trained in a general area, and you are working a specific job assignment.

Mr. Boucher: Unfortunately, many of the brilliant thoughts which have occurred to me, I have been so unwise as to bring up earlier. That makes my job now even more chaotic and less organized than it would have been. I work for WICHE, a 13 state organization, the equivalent of SREB. WICHE is supposed to be engaged among other things in developing manpower. The question is, how do you develop mental health manpower? First of all, how do you increase the sheer quantity of mental health manpower, and how do you maintain or improve or hone the sharper edge, the relevance of the knowledge of the mental health manpower pool?

I keep wondering about the professionals themselves as a part of the constituency which must be considered in a project like this. I don't agree at this point, for example, that this project could only work in a frontier community. I guess it was easier to launch this kind of innovation when an area has zero mental health services. You could say whatever you did, "Well, at least we are adding something where there was nothing." I guess that was reassuring.

But I think there is a great deal to be learned from a project like this which a great number of mental health professionals around the west should know. The problem in my mind is, how do you get them to learn it? In a way, we have the wrong people at this conference. We don't have the conservative professionals here. I can think of all sorts of mental health centers ringing the fair city of Denver, for example, which have a fair number of highly expensive, I guess well-trained mental health professionals. It seems to me if they were to take seriously the idea that one of the elements of a comprehensive center is the consultation and education element, if they were to take seriously the idea that much of their professional time should be spent as backer-uppers, as teachers, as consultants, they would have an opportunity even in the plush suburbs of enormously extending the impact of their services.

I met only recently with the staff of one of the centers in the immediate Denver area. They can talk about the need for new career programs in the east, in the ghettos, and they can bleed for the poor Indians who do not have services, but if you ask them to talk about how they propose to really meet the mental health needs of their fairly affluent area, they fall back on a very traditional model. I think these people ought to know what was done here. This is going to be a tough nut to crack, because I don't know how you teach these kinds of professionals. The ones you have on this project are mavericks. They are people out of a new frontier of knowledge, already half convinced we've got to radically change the mental health delivery system, to find new ways. But these people are, I think, in a great minority.

I see a desperate need for change in the mental health systems in suburbia as well as in the ghettos and on the Indian reservations. I have as much concern, I think, as anybody for the needs of the poor, for social action. This is a crucial element for most mental health centers. But I think it will be very interesting to see the degree to which social action and the needs of the poor and needs of a new constituency will be met right here in the next few years.

I see a tremendous need for change and I am not at all convinced this change is going to occur automatically. I don't have all the optimism some people have at this conference. Even in terms of social action, we have had the bold experiments of OEO and there is a massive counter attack to roll back these programs. We have had bold experiments in mental health and it's easy to assemble a group of mental healthers who will say, "Yes, we need to do things in mental health," but there are a lot of very conservative people who hold positions of power in the mental health establishment throughout the west. They are slow to change, and hang onto the idea that maybe they don't need to change.

A project like this raises fantastic questions, not the least of which is, what is the professional of the future to do? What is his role to be? You have shown, you have demonstrated that many of the therapeutic roles, and at least on a minor scale, the community organization roles, which professionals like to think are their particular bailiwick, you can train new people to do right here in the community. They don't have to be credentialed in quite the same way. Somehow the professional has to keep on top of all this.

I think there is still a place for the professional, the backer-upper, but it is a place he is almost going to have to re-earn his own credentials for. He has a bigger credentialing problem than the non-professional almost. He is going to have to re-earn his right to be considered an expert person with an enormous amount of knowledge, and flexibility, somebody you can lean on when you need somebody to lean on. The question of how you produce the professionals of the future is a fundamental question.

We haven't gotten into the question of the impact of these sorts of projects on university training. Somebody in one of the groups said he had sat in a number of lectures at the university where you sit in rows, tend to be half asleep and somebody writes on the blackboard. But the things he sat in on at Dona Ana Mental Health Services had much more meaning, far more impact. It was a better education, if you will. How do we get this message to universities? They probably ought to play a role of some kind in teaching people in the future.

I have more questions in my mind now about this project and the questions it raises than I had when I came here. I am disturbed, I think, by this experience.

Let me make two other points. One is, I think the problem of credentialing is a crucial one regardless of what some of you second careerists have said. You have said you really don't plan to leave the area, don't really care if you have a degree, don't care whether you can go to national meetings, etc. But this whole experiment, it seems to me, was based upon giving you a different kind of credential. You were credentialed. The constant emphasis on the fact you had consultants, they were here regularly, you could lean on them, seems to me was crucial in earning the saction from the community that the project was O.K. It was really all right for people to come in and see counselors who did not have diplomas on their walls, because those counselors were tied in with high level consultants. What you really did was create a new kind of credentialing system. One questions is, how viable is that in the long run, or must it be reinforced even more in the future?

The last comment was sparked by what one of my colleagues was saying about the alleged need to develop tight job specifications and to specify in rigorous detail precisely what kind of training people had. I guess we have to do this, but in my heart of hearts, I'm not convinced. I think if there is anything to be learned from modern management theory for example, it is that in the modern corporation you no longer set the corporation up the way Max Weber said you should 60 years ago. Weber said you have a task, you have a director up here and people under him and people under them. Before you ever hire anyone, you write the job specifications, figure out precisely what the job is going to be. Then you train somebody, hire them to fit that slot, and that's their role in the corporation. Most civil service systems are set up the same way.

There is a world of evidence from modern corporations and modern management theory that this is not the best way to get the most mileage out of people. To some degree at least with professionals, and probably with sub-professionals, you don't want things to be too tight. You may want to sketch out the job in some broad outline, but you want to give people freedom to innovate and make what they will of the job. I would hate to see all the people from this project now sit down and write out exactly what they do and decide this is what they and their successors will be doing from now on. I think that would kill the project in the long run; that is what the deadening hand of bureaucracy is. One of our tasks is to change civil service, to change the way we organize things. One of the lessons of this project is that here people did evolve roles. They evolved them on the basis of training, but they helped evolve their own roles.

Mr. Ontiveros: The professionals are really the ones who are asking for these things, because the non-professionals have no clout. The clout is all with the professionals. You're saying that somehow the professionals are wondering, searching for their own roles. Actually they are the only ones who have any control over that; the non-professionals don't. The professionals are the ones who are demanding the job descriptions and everything else.

Mr. Boucher: Some of the professionals; unfortunately, a lot of them. But look at what happened on a project like this: Libo came out and essentially got turned loose. Libo in turn found a few mavericks who were willing to go into a community with no preconception in any real detail of what they are supposed to do. Liz got turned loose, and in turn she recruited the kinds of people she felt comfortable in turning loose. I personally think this is a very important principle of modern management which has not yet even begun to be implemented in most state civil service systems, for example. There is a lot all of us, professionals and non-professionals, could learn from this if we just will.

Dr. Libo: I think I could sit down and write a job description that would fit state civil service regulations but the problem would be the salary would be so high and the title so important you might not want to apply the job description to non-professional people you would want to recruit! You might not want to pay them the high salary that would go along with such a high-level job description. When you start to think about it in the usual language of job description – assess community need, develop community resources, select community boards, train volunteers, supervise volunteers, render direct clinical services, make use of consultants – this sounds like a state, regional, or community mental health director's job. That's the frightening thing to people who have to write job descriptions.

Dr. Reiff: This brings up one of the important aspects of this project which I feel has not been emphasized anywhere. What this program is really all about is training paid volunteers to do a particular job, because the job cannot be paid commensurate with the work done. One of the pre-requisities for this job is the kind of people you select have to be people who volunteer their efforts primarily and are paid for volunteering their efforts but not for doing the job. This is an important aspect of the program, it seems to me, because it tackles a fundamental social problem in society. Somebody said yesterday, "It wasn't our intention to attack social problems; it wasn't our intention to deal with any particular grouping in society." It may not have been your intention, but I think you did anyway. Because what you did is demonstrate you have a possible solution to a very important social problem, centering around the question of what you do with a whole group of mature women who have raised a family and have no purpose in life anymore. It is not by accident, I think, that in selecting trainees you selected 15 women and one man. An important determinant must have been the nature of the program which you have designed, and the kind of people you could recruit for this kind of program.

So you really have made a contribution, I think, that can be applied anywhere in the United States. There is need for a program which trains people who have no more purpose in life, and yet have a great deal of creative energy and talent to contribute and no way to do it. I do feel that is a way of making life meaningful and useful to a whole group of people who are increasing in the United States.

Not only that, but looking further into the future, as cybernetion and automation increase, there are going to be another group of males as well as females for whom there is no room for absorption into the production segment of society, and they will have to be absorbed into the human service segment. It's going to create all sorts of problems about sexual identification and all those sorts of things. Because, you know, human service is generally regarded as female work unless you are a professional. But we are going to have to change these concepts; we are going to have to consider some of the really acute social problems we will face if we don't change them.

Dr. Sears: Your comments have sparked some thoughts about what Richard Cornuelle, who I believe is now with the National Association of Manufacturers, has said. He has been plugged in and intrigued for quite some time with the potential of a whole independent sector, which he distinguishes from the public sector and the private sector, the private practitioner. He talks about the independent sector as a whole "sleeping giant" of resources we have not yet really learned to use. I do like to think this project in some small way is beginning to work with this. As professionals, especially if we are identified with the public sector and the bureaucratic model and feel a responsibility to try to make it work, we are struggling with a situation which, at the risk of sounding pretty revolutionary, may be going by the board. I think the real changes are going to come at the grass roots level, through new models. We are going to be trying to make this old model work while this "sleeping giant" begins to wake up, move in, and get the job done.

Mr. Boucher: Let me nail this down just a little bit more. There is a great manpower shortage. We look around in poor areas and see people out of work who have talent and might have become doctors and engineers. It is ludicrous and absurd not to use them. Now maybe we are beginning to find out how to use them, and may even find out how to let them use us. The same thing is true, in terms of the woman power we have been speaking of. I think the use made of middle class women in the past by social agencies was equally ludicrous and absurd. The tendency was to put these nice ladies on our boards as window dressing with the hope their husbands would be important men, and maybe they could influence them. These women want to do volunteer work, so we let them drive people back and forth to an agency, or we let them collect baskets at Christmas time, or this sort of thing. It is fakery, and the women who are worth anything don't stay in it very long. I really think the merit of a project like this is, it shows these talented women can be given real work to do. They don't have to be locked into tight little boxes by overly rigid specifications. They can be released just like professionals ought to be, to do their work, and eventually they can even probably use their knowledge, experience and expertise to affect the professionals.

I'm sure it is true the trainees taught their consultants a great deal. The time ought to come when they should be able to confront the professional. They need to be able to affect the system and use their power just as the new careerist from the ghetto needs to eventually have this possibility.

Dr. Senescu: The implication of your remark, Dr. Reiff, was that human services in general and maybe in medicine entirely are seen to be woman's work. I would say that women do it more comfortably in terms of the service.

Dr. Reiff: I'm wondering if that is a cultural thing. It's not true in Europe, for example. In Europe male nursing is an established kind of occupation. In the United States we tend to think of people who go into male nursing as somewhat strange.

Mr. Ontiveros: I said this in the group before, and I think people disagreed with it, but I think generally in this culture we like to exploit women, the thing Stanley Boucher is talking about. I think it is not by accident this happens. It's so much a part of the culture people don't recognize it as that, and that's why it happens. When you look at it in that light, it is not a very nice thing to look at, but I think that's why it happens.

Dr. Reiff: Let me try to put this in a social perspective. I see a development in professionalism that I think has changed the whole nature of professionalism. I'm not an optimist; I think the change may be a very bad one. The question is, can we intervene in the social process to try to make it a beneficial change rather than a bad one? The social reform movement in the United States has had a tremendous impact on all the professionals. The impact has two aspects to it. One is the demand on all professionals that there be greater client responsibility and accountability. The other is a shift away from the one-to-one relationship to working with groups and social systems. This is the impact of the reform movement on all professionals, not just mental health professionals on lawyers, on everybody. Now some professionals are beginning to respond to that; others are not.

The interesting thing about these two aspects is they can not be successfully achieved without challenging some of the fundamental aspects of professionalism as it exists in the United States today. Take the first one, greater client accountability and responsibility. Research studies have shown if there is a conflict of interest between the client and the agency, the worker will in 90% of the cases decide in favor of the agency. There are a number of such studies; I don't see how anybody can challenge this. When it comes to accountability, the professionals insist they are accountable only unto themselves. As to the one-to-one relationship — why, a good many of the rituals, a good many of the symbols are associated with the one-to-one relationship: your private office, your confidentiality, the supervisory aspects, the rituals that go with professionalism. In order to achieve or to respond to what is being demanded by society today, we are really going to have to challenge some of these fundamental tenets.

So, in a sense, your program is responding to this social movement. First of all, you decided you were going to train people who were not bound by traditional professional rituals, morals, ethics, and value judgments, and you were going to train people to be project or program builders, developers. The implication is you are going to move away from the one-to-one relationship to intervene in social systems. I have a sense from what has happened in the project that although there was an intention to move away from the one-to-one into project development, the primary education was really in the one-to-one relationship. Would one of the trainees tell me what is a typical day in her life, whether she is spending more time with clients or whether she is spending more time intervening in systems? That would be an interesting way of evaluating what I see to be a conflict built into the system.

It seems to be a law of institutional change that an institution which develops an innovation in any kind of service seems to be the last one to adopt it. It is interesting to understand some of the laws of institutional change in order to get a proper perspective on the project, because I can see this project being taken up in many places in the United States, and New Mexico sitting by watching it develop and thinking, "You know, that's a good idea; we ought to do that one of these days."

There's a tremendous difference between starting an innovative project and implementing it. You can have an innovative project and do all sorts of wonderful things because for the most part, in order to accomplish an innovation, you have to do it sort of outside of the establishment, and you are. You sort of have one foot in and one foot out. But once you begin to implement it, you have to incorporate it into the establishment, and there is a tremendous amount of slippage. You will never be able to take an innovative demonstration project and implement it, institutionalize it, and put into a system, in exactly the same way with exactly the same wonderful results and the same enthusiasm that you can in your project. There is bound to be slippage; the question is, how do you minimize it? How are you going to prevent it in your new community mental health center in Las Cruces? It is important to try to understand this project in terms of the laws of institutional change, some of the forces operating on the project, and then decide where you go from here with it.

Also, there is some expression of a need of credentialing of some kind, and for a career ladder. It wasn't always that way, but in the United States today, professionalism is the only career ladder, the only way you can move up. It seems to me it is unkind, unwise, even immoral to say to a person, "We are going to train you and this is going to be your job the rest of your life," without affording some kind of career advancement. You have an obligation to your new careerists to help them develop. Why not even, as though they were gods, make them professionals?

Then you are faced with another dilemma. Should everybody become a professional? And, what does this mean in terms of what professionalism is? It seems to me the only way is to build in a career ladder, but at the same time be constantly recruiting new people in the non-professional area so you have a constant influx of people who are introduced into the first stage of the career ladder. It has to be built in as a continuous process. Your old trainees (I don't mean age) can become the trainers and the supervisors of the new ones, and this is your next step in the career ladder. They can graduate into trainers, supervisors and educators of the new people. It seems to me it is important to think about the implications of this project in terms of career ladders and where you go from here.

Dr. Cumings: Suppose they don't choose that route? Suppose they cop out and choose to continue to do what they are doing? Not that these people wouldn't be very helpful and valuable but they may not choose to go the so-called professional route that has stuck so many square pegs in round holes, once removed from active involvement.

Dr. Reiff: I think they ought to be punished. . .No, seriously, that is their choice, I am not saying they have to graduate, that they have to go into new careers.

Dr. Libo: What if society somehow decides that the greater payoff is for people who are in functional roles rather than credentialed professional roles? Many of the leaders in the community who are given a lot of responsibility are good administrators, but are not all of the professional group. What if these people were to start a real change in society's view of who does what kind of work? If they were given the leadership roles in administration, and they used the professionals for certain technical sub-specialties?

Dr. Reiff: It's an unfair question. . . It is just not the way society is going. Maybe sometime it will, and we will have to tackle the problem on that basis, but I don't see any movement in that direction. All I see is that everybody wants to be a professional, even the administrators. For a reason: the professionals in the United States have now become the fifth estate, a tremendous power group. They are now advisors to the legislators. They shape public policy. They have become the organized expression of the middle class in contrast to 25 years ago when the organized expression of the middle class was the shop-keeper, the small businessman. We live in a society that is rich enough and has a large enough middle class to buy up all the human services available in the United States, leaving nothing for any other segment of the populations. That's a powerful influence to be, and the professionals therefore are in a seller's market.

Dr. Libo: Don't you get the feeling that you are trying to protect them more than they feel the need for protection?

Dr. Reiff: I'm not trying to protect the professionals at all; if you want to be truthful. . .

Dr. Libo: I mean the trainees.

Dr. Reiff: I'm trying to protect the trainees? In what way?

Dr. Libo: All of the urging for credentials and for protection for their own good.

Dr. Reiff: No, it's a sneaky strategy that I have to destroy the professionals. I want the non-professionals to have credentials and I feel that because they are doing what they are doing, which is different from what the professionals are doing, they will expose the professionals.

Mr. Ontiveros: The question that I have is, why don't the professionals want the non-professionals to have credentials?

Dr. Libo: Some do.

Mr. Boucher: It seems to me that part of what Les was saying has to do with Jeffersonian democracy. In the old days, everybody would have his own little field, till his own field in his own way. He would know everybody in the village and the town meeting. You did not need to say, "We'll let him speak because he has a degree," or, "Let him speak because he has the credentials." Everybody earned their own little place in the community in the course of a lifetime. To a certain degree it is possible that is even true in a small town like Las Cruces. You can say there is a pool of second career women who plan to live the rest of their lives in Las Cruces. They know each other and they can rely on the informal social system to know who is competent to do something and who is not competent. To a degree we could even build on that. If one of these women was moving to Denver, for example, Les Libo is know in Denver, and he could write a letter of recommendation to a friend and probably get one of these women a job there. So to a certain degree you can do this, but by and large the professions have not come about through their own gluttony, or through a process of random chance. They have come about because in most sectors of this country, people are enormously mobile. They move all over the place, and you have the constant problem of how to know who is fit to do what.

Dr. Libo: One answer to that question is evaluation of impact and effectiveness of the service. If the professionals would yield themselves to this scrutiny of evaluation, I do not see how over the next ten or 20 years county commissioners and state legislators etc., are going to be able to ignore the results. What if the data says: "Here is a guy who has a certificate and here is a guy who doesn't." "The guy with the certificate is hurting people and they are not coming back. The guy without it is doing all the service." I'm not saying that it will come out this way. . .

Mr. Boucher: That may be, but the county commissioners are never going to let Mr. A and Mr. B come into the community and start doing things; they are going to demand some reason to think they are competent. You know, the search for competence.

Dr. Reiff: You are all thinking about county commissioners as though they haven't changed or won't change. County commissioners are usually astute politicians, and if you develop a constituency, an astute politician will pay attention to that constituency. In fact, county commissioners are often more accountable to the constituency than mental health professionals are.

Dr. Libo: I think the day of the exclusive reign of the professional is going to end when the cold eye of evaluation takes more prominence in the judgment of programs.

Mr. Boucher: When that happens, all you are doing really is substituting a new way of credentialing people and probably a much better way than we have now.

Dr. Sears: The professionals are a pretty hardy crew, and I don't fear for them. I have worked with people such as those who have worked here for ten years now, and they are a hardy crew, and I don't fear for them, really. I'm not too concerned and I don't think they are, with this credential — no credential thing. I'm troubled that we are hanging up too much here. There is something exciting which has gone on here but we are losing touch with it. These trainees were able to get in touch with the people in this community. It was a very exciting thing, for example, to go to a room like this and see 30 people in that room — some of them college professors and some of them blue collar workers — who were there because they were interested in working with the pre-delinquent adolescent. This is that "sleeping giant" that somehow these people were able to get in touch with.

One thing that did not come out in the large group discussion was a fact we missed in a very wholesale way in the initial planning for this project, the extent to which these trainees had their own sphere of influence within the community. Each by virtue of being who she was, could plug into a tremendous segment of this community in a way that Liz and I were not about to. We had the erroneous idea that we had our foot in the door down here, and we were going to help these people get their foot in the door. We couldn't have been more wrong. Each one of them brought their own sphere of influence, and it was that sphere of influence they plugged into. This morning when we opened our panel, I was delighted to see Alice Gruver and Margaret Day talk about this program with as much feeling, conviction and an attitude of ownership as anyone here. They are the only two of the administrative volunteers that have been visible here, but there are many more like them.

Dr. Senescu: One thing that I felt very keenly, is that we emphasize the individual as a means to an end. In a sense, it was not for the so called "one-to-one" reason. But if we are going to spend a million dollars, sooner or later you have to get back to Mrs. Klotz as we used to call her in the Bronx. What are you going to do for Mrs. Klotz? Does she get anything out of this million dollars when she comes into that system? I think we need to get a balance between the number game on one side and somehow treating individuals as human beings. Do they come out of it as better human beings? We seem to be in an either-or trend. In this project, watching certain of the young trainees come into it, the one-to-one was the last go around that was wanted, but it seemed necessary.

Dr. Libo: One thing that came to mind as you were talking, Bob, was that there was a reluctance to give the trainees training in group therapy, in group methods, until very late. I was always interested in this, but for some reason this was considered more difficult, or more technical, or maybe you weren't as comfortable with it, Liz.

Miss Madore: I had the misconception that the best way to learn to work with groups was to have experience in a group and to learn from your own experience in the group, and you know, that flopped three times.

Mrs. Stearns: I work with the emotionally disturbed children. We did have some group therapy for the children, but most of the children were quite young, and play therapy seemed more appropriate. I spent a lot of my time on a one-to-one, not only with the children but with their parents. I come in at eight-thirty, greet the children and the volunteers, and if they have problems I feel I can help them with, I try. I just do whatever comes up.

Dr. Reiff: I see a problem of communications. When I talk about social system intervention, I am not talking about working in therapeutic groups at all. I'm talking about something entirely different.

Mrs. Carpenter: My program may be an example of what you are talking about. I came into the juvenile program after it had already been started by another trainee. The probation department had requested a body of volunteers to work on a sort of a big brother basis for their pre-delinquents. We had some series of training sessions for volunteers. I spent a great deal of time organizing a board, not the money men, not the legitimizers, but the workers: businessmen, lawyers, professional people not representing an agency, and an advisory board representing agencies. Next, I had many referrals from doctors, from the school system, etc., for individual work with juveniles. That day would start with community contacts, and wind up (because the kids couldn't get there until after school) with groups, and then evening meetings, board meetings that would go on until eleven o'clock at night some times. I started two therapy groups, one for boys and one for girls.

Dr. Reiff: You were doing a combination of social system intervention and other. How typical was this?

Miss Madore: It was not atypical.

Mrs. Williams: I worked with the public school to implement programs that were valuable for the children. I was working with professional people, representatives from universities, and getting together proper materials for the children. I was working with volunteers to train them to be effective in working with the children. I did individual client handling, tried to spend part of my day in reading, or enlarging my own knowledge, many, many things. I was training a teacher, working with the board. And there was a great deal of contact here in the office, reality testing, an informal feeling that when the time came that I wanted help, I could get it. It was on the spot. It was not as though I had to compile a long list and had an hour to get all the answers. It was an easy way.

Mr. Boucher: This underscores even more the fact that what we have here is not a project that just trained technicians on the World War II model, where you broke up the craft union job into a series of little pieces. These people were eventually designing their own ships.

Miss Madore: Creating their own jobs and their own organizations.

Dr. Reiff: Right. I said that yesterday. I think one of the unique contributions which this project makes is that it wasn't training project or program developers to just be program developers. What they were doing was training people to develop an institutionalized program to be able to do what they want to do. In other words, there was a specific relationship between their training and a particular job, which is very important. Most of the failure in job training programs today is because people are trained for jobs in general and not for a specific job in particular, and then they find that over 50% of the people never take advantage of the training they have gotten. One of the important aspects is to train a person for a particular job.

Mr. Moncrief: How were people trained to do this, Liz?

Miss Madore: I discussed the jobs with them when they were selected, and we identified some of the elements. The training was designed to expand these elements.

Mr. Staton: This raises a question in my mind. Can you now with your center established, bring in trainees and fit them into your program? In other words, how do you think you can train new workers to do their thing in an established program?

Miss Madore: I wouldn't hire people that I didn't feel comfortable to turn loose. I have hoped to train trainees who will keep after me until there is no conflict of interest, and they can do what they really want to do.

Mr. Staton: Doesn't this raise a question of whether you really had a training program?

Dr. Hadley: You had a non-traditional training program. You had a living experience training program. I am not sure that the question of curriculum is relevant to raise at all.

Mrs. Neleigh: Let me answer the question of training a bit specifically in relation to a six month period from which I made this graph. We had nineteen percent of total time in this six month period that was just for training, nothing else. It did not involve a client or program. We had: (1) Classes and Seminars. (2) Team meetings, which got together the children's workers to discuss children's problems, etc. (3) Outside learning experience, such as conferences at state hospital. (4) Individual conferences with trainers, initially with Liz and Bill and later with consultants. (5) Individual conferences with other trainees. When we got a new children's worker, we assigned him to the last children's worker for orientation, etc. (6) Teaching experiences. We would take some such topic as Erikson, growth and development. A trainee would be assigned the first stage, to read, reference and teach in the next class period. We did have some such structured stuff as this. We had close to 30% of total time devoted to it in the first phase. It dropped off radically in the middle and we got into trouble, so we reinstated a fair amount of it in the last phase.

Dr. Reiff: One of the things which I feel to be an important lapse in your data is how the professionals were trained by the non-professionals.

Dr. Newman: We don't have longitudinal data on this.

Dr. Reiff: I know. But I certainly think there must have been a considerable amount of training of the professionals by the non-professionals. This is an important aspect that has to be discussed in your final report.

Mr. Ontiveros: I was struck with this yesterday. I thought there was a paradox when two or three times in one of the initial presentations you said you wanted to be sure you had sufficient professional expertise, but thanks to Les' honesty, he was able to get up and say, "Look, I was a student throughout the whole process." You know, somehow we got to blow that scene, like we've got all the answers.

Dr. Newman: We have no data on it. As a matter of fact it was damn fortunate for research to come into this sort of a project because the professionals would never really let us analyze what they are doing, but these poor non-professionals were in no position not to allow us to.

Mr. Boucher: Maybe they will learn to fend you off.

Dr. Reiff: You know, your model really is interesting, because we want to do some research in the community, in the community corporation, and for a long time their attitude was, we don't want you to research us. We are sick and tired of having people come into the ghetto and research. We never get any feedback, and nothing changes in our lives for your research, so keep it. So we made a counter proposal. We say, "O.K. You select people from your community that you want to be trained as researchers; we will train them and they can do the research. Then they will be part of your community."

Dr. Newman: Two things were fruitful about our model. Number one, Jan was a non-professional. Number two, we did not have a control group. We had professionals as a reference group representing the field; they were part of the experiment.

Dr. Reiff: I was impressed by one thing in your data that no conclusions were drawn from. That was that although the emphasis was on program development, the non-professional felt that the greatest gratification he got and the thing he liked best about his job was therapy, counseling. Now, I'm curious about how that came about. Again, I'd like to do an institutional study to see how that came about. That's a very important finding. You are training program developers and they tell you that the greatest gratification they got from the training was to do therapy.

Dr. Shelton: The corollary of that was that they all said, I believe, that they could lose themselves, forget their own problems when they were therapists.

Dr. Reiff: Our time is getting short, and I think I should make our time as valuable as possible. One question that has been asked is what can be doneabout the final report.

A Participant: I think descriptive approach that calls it like it was is the only thing that can be of benefit. . . Anything else will be a sterile document. . . Don't pull any punches, or it won't be of any use, really.

Mr. Boucher: Recently, I heard a talk about the role of the universities and libraries in the modern world. The speaker said the real function of libraries was to lose as much knowledge as possible because we're just cluttered up with useless de-fanged sterile publications. Really, that's the choice you have. How much risk do you take? How much do you level with us? From the point of view of outsiders, there are some major issues here which it would be nice to see you confront. You've launched a major assault on Machiavellianism. You've launched an assult on the professional mystique.

Appendix

I. Conference Agenda

II. Background: pre-conference mail-out

III. Research Approach: presented at the conference.

IV. Abstracts of research findings: Papers mailed out and/or presented at the conference.*

V. Role description: sample of role description at close of the first project year.

VI. Retrospective judgments: Each of the following were compiled from data collected at the close of the project.

   A. Role description: a composite description of what the trainee should do, as viewed by staff professionals and non-professionals.

   B. Criteria for selection of trainees: what non-professionals and professionals saw as most important characteristics.

   C. Criteria for selection of consultants to non-professionals: what non-professionals saw as most important characteristics.

   D. Training Curriculum: training experiences trainees viewed as most valuable, with percentage of time based on amount of training offered to trainees who felt adequately trained.

VII. Conference evaluation

VIII. A postscript: "To Tell It Like It Was"

IX. Roster of staff and participants

X. References

***Research evaluation of the project has been submitted for publication as a special monograph and will be available by writing to J. Neleigh, Rt. 2, Box 21, Las Cruces, N.M. 88001**

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Conference Agenda

Utilization of Non-Professionals in Community Mental Health
Projects as Demonstrated by Dona Ana Mental Health Services

March 10, 1969

8:30 **Registration**

9:00-10:15 **Basic Philosophical Assumptions and Project Objectives: Background**
Lester Libo, C. Elizabeth Madore and William Sears

10:15-10:30 Coffee Break

10:30-10:55 **Project Overview**
Jan Neleigh and Harriet Pinnock

10:55-11:10 **Training Concepts**
Robert Senescu

11:10-12:00 **An Example of Project Implementation: Development of A Children's Center**

C. Elizabeth Madore—TREATMENT GOALS
Lee Carpenter—CONTRIBUTIONS OF COMMUNITY
Betty Williams—EDUCATIONAL GOALS
Cecelia Tolliver—VOLUNTEERS
Lester Libo—ASSESSMENT OF FACILITY

12:00-1:00 Lunch

1:00-2:15 **Project Evaluation Data**
Fred Newman and Jan Neleigh

2:15-2:30 Coffee Break

2:30-4:00 **Small Group Discussions** (Such topics as selection techniques, training techniques, role of consultants, roles for non-professionals, etc.)

GROUP I Robert Senescu, Elizabeth Madore, George Gliva, Cecilia Tolliver, Lee Carpenter, and a board member.

GROUP II William Sears, Jerome Levy, Betty Williams, Byron King, and a board member.

GROUP III. Lester Libo, Jan Neleigh, Amy Stearns, Harriet Pinnock, Rena Wright and a board member

March 11, 1969

9:00-10:15 **Impact of The Project on Community and State**
William Sears, Robert Senescu, William Shelton, Alice Gruver, Margaret Day, Mike Neal, Pat Johnson and Judy Nixon

10:15-10:30 Coffee break

10:30-12:00 **Small Group Discussions**

Same groups as March 10.

12:00-1:30 Lunch

1:30-3:30 **Applicability and Generalizability**

Dr. Robert Reiff will moderate a panel of selected conference participants to discuss what they see as valuable and usable in their own programs. Hopefully, then, general discussion by all participants!

Note: The opening sessions will be presentations of formal papers including necessary background material, essentially one-way communication. Sessions following will be tailored to specific interests of participants and will encourage two-way communication.

Background Information

Exploratory Methods of Utilizing Non-Professionals in Mental Health Roles

For five years, Dona Ana Mental Health Services has administered a project entitled "Training Non-Professional Community Project leaders." The stated objectives of the project were to "explore the effectiveness of a special method of selecting, assigning, training and giving consultation to non-professional mental health workers as they and the community develop specific mental health services and to educate the community to participate effectively in these services." The objectives imply a division of responsibility and concern. The subject of concern to the project investigators was the non-professional trainee who was to be studied in terms of what he should be like, what he could do, how he could be trained and what supports he needed from professionals in order to successfully function as a mental health project leader. The concern of the trainee was development of a service project with the community which the community needed, wanted and could contribute to.

The project was designed as a demonstration-study. Skeletal criteria for selection of non-professionals and projects were outlined in the grant proposal. No specific method was outlined for selection, role assignment or training of these workers. Hence, methods were operationally defined and were altered at any point the methods of selecting and equipping the trainees were not producing motion toward the service objectives of the study.

The freedom to change methods at any time they did not suit the apparent needs of the organization was viewed as necessary and desirable. It did dictate, however, that the project be reported not as research of a method but as a study of the effectiveness of several methods. For the purpose of comparison, we have elected to report the project in three chronological phases which most nearly place boundaries on and allow for measurement of distinct and different methods. Phase I is defined as the first project year, Phase II as the second and third project years, and Phase III was the fourth and fifth project years.

Phase I: During Phase I, Dona Ana Mental Health Services was established as the parent organization for the trainees' projects. Trainees hired during this phase (Group I) were selected on the basis of the skeletal criteria for leadership outlined in the grant proposal. General considerations were basic intelligence with a minimum of a high school education, experience related to some element of the job, a need to serve, an open-minded approach, and a non-controversial image in community.

Roles assigned were defined on a step by step basis: (1) develop identity as a mental health worker, (2) develop relationships needed to develop the assigned project, (3) develop a plan for giving service, and (4) provide service. The scope of the job for which each trainee was hired included developing, promoting, providing and coordinating activities which the professionals prescribed. Freedom of role design was confined to a trainee's finding a method which felt right to him to accomplish what the professional determined he should do.

The order of role development was changed during the first year to allow the trainee to give one-to-one client service before he developed a community project. The rationale for the change was the trainee could design a project most in line with the needs of his client population if he first had an opportunity to adequately understand the needs of this population. A professional staff member was involved with intake and screening of each client during this phase.

Training during Phase I was designed to give the trainees an understanding of the fundamentals of mental illness and therapeutic relationships. It was didactic, but highly personalized. Group training included weekly classes or seminars, and weekly staff conferences for discussion of case loads. Individual training included a scheduled individual conference with the director, on-demand conferences with the director, and observation of the directors' client handling techniques.

Consultants during this phase served principally in their usual professional roles, i.e., the psychologist did psychological testing and the program analyst designed a research format.

The organizational tone of Phase I was highly positive. Trainees each made monthly oral recordings in which they discussed what they found especially rewarding, what they found discouraging, and what they learned that modified their behavior. These recordings were coded, placing each response in one of four categories: (1) self; (2) clients; (3) organization and (4) outside systems. Each response was rated as positive, negative, ambivalent or neutral. Every category during this period was dominantly positive. The category of both highest responsiveness and highest positive response was "organization," which was defined as everything within the organization except one's self and the clients, i.e., other personnel, administrative policy, training, etc. Trainees' highest ambivalence ratings were to "self" and "clients."

As Phase I was viewed by the director in companion recordings, her dominant positive response was also to "organization," especially to the development of the trainees. The director's dominant concern was "outside systems," both some specific resistances from community groups and the problem of general acceptance by the community.

Phase II: During Phase II, the selection criteria were enlarged to include the personality of the trainee and his methods of meeting personal crisis, changes which emphasixed qualifications assumed to be important to therapists. All criteria were given greater definition and a flow chart was developed as a tool for evaluation of interview material in relation to the criteria. The success aura accompanying Phase I prompted the director to see if role-training-consultation methods being used would work with anyone, including someone who did not fit the criteria for selection. This ill-fated experiment gave impetus to greater definition of criteria as well as more careful adherence to them. Eight trainees (Group II) were hired during Phase II as compared to six during Phase I.

Roles were re-defined during the second phase also. Trainees were assigned a particular kind of client (i.e. suicidal, alcoholic) as a first step in developing a community project. Administration felt if each trainee could become a specialist about a particular type of client, he would develop enough expertise in a limited portion of the psychiatric field to enable him to assume major responsibility for his own client load. Trainees were doing intake interviews and discussing cases with professionals, but each case was not necessarily seen by a staff professional.

In sharp contrast to the detailed step-by-step role definition used during Phase I, Group II trainees were asked to define their own roles. Several opinions suggested this change. Group I trainees seemed to want latitude in designing their roles. The trainees had different inroads to community, an approachability, and a personal style that differed from the professionals. In an attempt to capitalize on these differences, trainees were assigned a type of client and given a work load quickly, without weeks of pre-client training and without boundaries or details of their roles defined for them.

Training was also changed rather radically during Phase II, because of combined forces of necessity and design. Training was now aimed at the personal development of the trainee. The didactic training offered in classes and seminars in Phase I was largely replaced by sensitivity type group training. The personalized individual training provided by the directors in Phase I was replaced by a more eclectic approach. Consultants from the disciplines of social work, behavioral psychology, clinical psychology, psychiatry, occupational therapy, and education were available to any trainees who signed up for scheduling with the next consultant who would be available. Trainees could ask for consultation about evaluation and handling techniques for a particular client, or as time permitted, any other troubling subject. Each trainee was exposed to consultants from several disciplines, but did not have a professional who was well acquainted with the particular problems he faced in his project at any given time.

During this period when trainees asked for consultation as they wanted it, it became apparent they had a great deal of preference for some consultants over others whose qualifications were similar. As a result, criteria for selection of consultants was added as a study dimension.

While a highly successful community project, the school for retardates and a promising adult activities center were initiated during Phase II, and the staff handled a peak client load, Phase II constituted the most negative project period. Notably, the category "organization" which had elicited the highest positive response during Phase I elicited the highest negative response during Phase II. Group II trainees felt less trained, less identified with the mental health field, and less autonomous than Group I. Six of eight Group II trainees left the project.

Phase III: During the third and final phase, the fourth and fifth years, many methods were modified to a point between methods of Phase I and II, but in most respects more like Phase I than Phase II.

Selection criteria were unaltered, though some changes were made in the interview format. Three trainees (Group III) were hired during this final phase.

Role assignments were relatively specific during the last phase, with much of the definition prevalent in the first period. The new trainees were allowed latitude in choosing techniques they found comfortable and trying particular ideas which appealed to them provided these fit within the bounds of pre-determined administrative goals.

Classes and seminars offering didactic training were reinstated. Group sensitivity type experiences were continued. The training was re-personalized on two dimensions. The new trainees were given the personalized attention by the director offered to Group I. In addition, consultants were given an entirely new role. Each consultant was assigned to one trainee and his project, and became involved with the trainee in his entire project. That is, the consultant shared responsibility with his trainee for clients, program development, community education, volunteer training, etc.

A crisis center offering services including 24-hour telephone answering service, an alcoholism program and a juvenile program were initiated as community projects during this final phase.

The dominant problem of the last phase was built into the plan. The fact funding would cease and the parent agency would close made it essential for staffers to plan their own futures and the futures of their projects or face having the projects close.

Research Approach

Frederick L. Newman

Abstract Introductory comments on research antecedents and methodology. Given 10 March 1969.

Often in the past, the key to evaluating a demonstration project, merely as a demonstration of an idea and not an experimental project, was to keep careful records of the project's activities over the period of its activity, and report this case history or diary to the field for its retrospective analysis. While such an analysis is crucial to the understanding of any project's activity, and as such, has served as an important stimulus for innovation, there are obvious limitations in developing generalized conclusions.

In the fall of 1967, the Dona Ana non-pro project attempted to make a shift from the collection of case history type data to data more specifically tailored to testing of hypotheses, from the literature and from conjectures made by the project's personnel. While this effort was relatively late in coming, the results probably represent a reasonable contribution to the mental health field.

At this time I would like to briefly discuss the task of data collection, hypotheses testing, and in general empirical evaluation of projects of this sort.

While several of our colleagues urged us to abandon efforts of empirical analysis of such behaviors, claiming the parameters underlying these behaviors are beyond empirical evaluation, we felt such an explanation was too restrictive. When we attempted to find an appropriate methodology, we found the literature offered little guidance. The "good" research designs required a rather sterile setting and/or a large **S** pool, e.g., graduate students in graduate programs or nursing students in nurses training programs. In our case, like many newly created community centered projects, we had neither the autonomy, stability nor an adequately large sized **S** population to invoke the nice experimental designs or the nice statistical procedures. Since we started the evaluation in the last year of the five-year project, longitudinal measures were not possible. And, finally as you should have realized from the information presented this morning, achievement measures, typically employed in educational settings, could not be used here.

We finally developed an approach which may have suffered the logical impasse of looking for the coin one lost in the dark alley by searching under the street light on the main street. Because of the nature of the project, we had two major groups to work with: the professional consultants (i.e., the two co-directors and about 10 other professionals) and the 17 trainees. The consultants as a group served as our reference group to which the trainees' behaviors were compared. That is, one basic assumption was that the measurable behaviors (e.g., attitudes) of the consultants were closely representative of the field of community mental health. With regard to the trainees, a post hoc bit of logic suggested these trainees fell into three groups on the basis of the point in time they entered the project. The three time groupings made sense only in terms of changes in administrative policy regarding trainee selection, technique of training, utilization of consultants and the like. The design now involved potential contrasts among the three trainee groups and between the trainees and professional consultants.

We resorted to collecting data from other available **S** pools to answer certain questions. These other **S** pools were: volunteer workers in the crisis center, graduate students taking a guidance course at the university and the women in a professional-business women's group.

The questions we asked came under five headings: (1) trainee selection, (2) training technique, (3) the role and selection of consultants, (4) the role of the non-professional mental health worker and (5) approaches to the development of community projects. We then constructed questionnaire items which reflected any or all of the following sources:

(1) the stated intent of the original proposal,
(2) the administrative policies of the co-directors, e.g., trainee selection and training techniques, and
(3) the hypotheses and conjectures in the literature.

All items were developed by their face validity, although we were able to check many of the questionnaires for ambiguity or bias by first administering the questionnaires to the graduate students in a statistics course I am teaching.

For our own edification, we used a rather large variety of techniques of questionnaire construction, e.g., Likert scales, first associations, rank ordering, semantic differential and scaling the intensity of **S** attitude on a real line. With regard to the latter technique, real line estimates of attitude intensity, we also varied the number and position of anchor points.

Within a particular questionnaire, we typically broke the items into two parts. In the first part, the **S** had to scale various characteristics in terms of the ideal case, and in the second part, these characteristics were repeated and the **S** had to scale his perception of himself in terms of these characteristics. Typically, when asking **Ss** to scale a characteristic, we would follow each item with the request that they scale "how important" that characteristic was to the idealized role of the trainee or "how important" that characteristic was to the idealized role of the consultant.

Example

(1) With regard to **authority**, a trainee should:

. ____ .

Be completely at ease having authority	Be completely ill at ease having authority

(2) **Importance** of the above to job performance is:

. ____ .

Extremely important	Not at all important

On a separate form the characteristic was repeated, asking for self-evaluation.

(3) With regard to authority, I am:

. ____ .

Completely at ease having authority	Completely ill at ease having authority

This approach proved to offer powerful interpretation. One result was quite interesting. Characteristics scaled to be very important, typically were items for which there was much less variance among **Ss** responses.

Still another technique which produced interesting results was asking **Ss** to scale their **confidence** in the scaled response they made to a particular item. Apart from information gained on the content of the questionnaire, the technique of scaling confidence of a response had an interesting side effect. The questionnaires employing this technique resulted in unsolicited marginal comments from the **Ss**. These comments are best described as --the **Ss** felt more comfortable or at ease in answering an item if they were also able to state their confidence in their responses. This is obviously a topic worthy of further investigation.

In summary: Our technique of grouping the trainees and making contrasts with the professional consultants allowed for a fair degree of generality in intepretation.

Furthermore, the extensive use of repeated measures (e.g., ideal-self perception, importance and confidence) allowed for relatively efficient measurement.

The greatest problem facing us in analyzing the data was in discerning the unit of scaled measurement. We decided on strategy which rested on untested assumptions. We used parametric test statistics calling for an interval scale only where we conjected the scaled dimension to be **not biasing** the data **in favor** of our hypotheses. That is, parametric statistics were used only in conservative instances. Otherwise, we used distribution-free statistics. Furthermore, we refrained from using the more sophisticated techniques of analysis, e.g., factor and multivariate analysis of variance, for several reasons in addition to the problems of measurement. Group size is the most obvious reason. Another reason was Mrs. Neleigh was a trainee and we wanted her role to be more than a statistical clerk's position, so I kept analysis at a "straight-forward" level. As it turned out, I may have been too conservative here.

Another area of concern in our analysis procedure was the question of error rates. With some 900 data points per **S**, it would be surprising if something wasn't significant at the .05 or .01 level. While we think we were cautious in our interpretations of statistical significance, we would like to see several replications of some of our results before we accept their validity. On the other hand, most of our reported significant results were in line with the literature and we have more confidence in these data. I am sure that most of you will find several aspects of our results controversial, and such controversy ought to be the stimulus for more research.

Abstracts of Research Findings: Papers mailed out and/or presented at the conference.*

Non-Professional Community Mental Health Project Leaders

I. Selection

Abstract

This paper discusses criteria for selecting non-professionals for roles as community mental health project leaders. Criteria for leadership and for therapy were rated on dimensions of role ideal, self-perception of the non-professional, and importance of each criterion to job performance. Subjects included 15 non-professionals, 10 professionals, and a control group of 10 graduate students. Professionals and non-professionals rated personality characteristics assumed important to therapists such as self-awareness and empathy as the most important criteria for the community project leaders. Leadership criteria such as social confidence and ease with authority, however, distinguished non-professionals who started projects and stayed with the project from those who did not.

II. Training

Abstract

Two training procedures were compared in a demonstration project. In training Groups I & III, nine subjects were given highly individualized training along with classes and seminars. In training Group II, eight subjects were given access to professional consultants and after a brief training period, use of consultants as trainers was mostly upon subject demand. A variety of questionnaires were given to the non-professional groups and 10 professional consultants involved. Six of the nine subjects from Groups I & III and two from Group II stayed with the project until its termination. Groups I & III felt more closely identified with the mental health field and were more satisfied with their training than Group II. In contrast with the professionals, all trainees valued structured and formalized instruction. A variety of parametric and distribution free tests were used as p-values were no greater than .05 in any case.

III. Consultation

Abstract

The criteria for selecting and the role of professional community mental health consultants were evaluated by 15 non-professionals and 10 professional project

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See footnote page 54.

consultants. As criteria for selecting consultants, non-professionals thought the consultant's willingness to listen and ability to communicate were most important, and such dimensions as liking the consultant and having the consultant agree with them of low importance. On the other hand, consultants were concerned with what non-professionals thought of them. Training was viewed by all groups as the most important role of the consultant. Non-professionals indicated that professionals should see more of the clients and be more prescriptive of techniques of handling clients than the professionals thought they should.

IV. Roles

Abstract

Roles for non-professionals as developed on this project are discussed on dimensions of definition of specific behaviors, consensus of expectations, and establishment of accepted status. Data were collected from 10 project professionals, a control group of professional women, eight non-professionals who had relatively defined roled and seven non-professionals who had little role definition. Professionals and non-professionals indicated agreement on what the non-professional should ideally do. Non-professionals who had little role definition differed negatively from all other groups on job perception as it compared to job expectation; most left the project. All groups felt the non-professional had made a valuable contribution, but thought he needed greater acceptance to have an established role.

V. Program Development

Abstract

Non-professional trainees were assigned to develop mental health service projects in an area where no formal mental health services existed. Initial projects were planned first and then enlisted community support. Later projects involved community on a planning and administrative level. Data collected from 15 non-professionals and two professional project directors suggest that community involvement at every level of planning and development enhanced the project's chances of success and may have differentiated this effort from governmentally sponsored action systems as discussed by Warren and Hyman (1966).

Sample Role Description at The End of The First Project Year: Coordinator of Services For Infants And Children And Associate Coordinator of The Children's Center

A. Relationship with director and co-director
   1. Director assists in initial interview of client.
   2. Consultation from co-director concerning cases as needed
   3. Individual conferences with director concerning self-appraisal and procedures of handling cases.
   4. Participate in case conferences with director and co-director.
   5. Have additional unscheduled conferences with director as needed.

B. Relationship with staff personnel
   1. Work with associate coordinator at children's center. Discuss events at center and plan activities.
   2. Share information concerning people, agencies, and attitudes concerning mental health.
   3. When appropriate, share information on cases carried with other trainees.

C. Relationships with community organizations, agencies and professionals
   1. Inform community of services available.
   2. Include agencies and professionals in coordinating services to clients.
   3. Recruit volunteers.
   4. Accept referrals from any source.
   5. Maintain liaison with schools.

D. Relations with clients or potential clients
   1. Explain services and procedures during initial interview.
   2. Arrange for evaluation of children.
   3. Inform appropriate persons or agencies of diagnosis and recommendations.
   4. Work with parents
      a. discuss progress of children
      b. attempt to teach parents techniques for handling
      c. offer family counseling when necessary.
   5. Explain recommenations and suggest methods for implementing them.
   6. Follow-up to see if recommendations are carried out.
   7. Share visitation with volunteer social worker.

E. Procedures for In-service education
   1. Participate in staff conferences.
   2. Participate in monthly volunteer staff conferences.
   3. Read pertinent material.

4. Attend training classes and seminars conducted by the director, co-director or associated consultant.
5. Observe consultants interviewing clients.
6. Attend appropriate workshops, meetings and courses concerning emotionally disturbed children and retardation.

Retrospective Judgments

A. **Role Description**: a composite description of what the trainee should do, as viewed by staff professionals and non-professionals at the close of the project. Note that the role involves training, development of a community project, and administration of that project. A minimum of two years should be allowed from date of hiring to expected full role performance.

Role of A Community Project Leader

Responsibilities, General

To develop a service project with the community to serve the needs of a particular client population, such as juveniles or people in crisis situations. Each project is to meet minimum requirements of being one which the community needs, wants, and can contribute to.

Responsibilities, Specific

1. **Responsibility to The Parent Organization, DAMHS:**

   a. To the Board of Directors of DAMHS
      (1) Account at any time during the planning or operational phase of each project for its status in terms of community support and client care.
      (2) Work with the DAMHS board member assigned to the project on the development of each of the items under section II.

   b. To the Directors of DAMHS
      (1) Keep the directors well informed about all phases of the project development and operation.
      (2) Request assignment of a consultant for developmental and operational phases of the project.
      (3) Attend all staff meetings and training sessions provided by DAMHS.
      (4) Request special training experiences appropriate to the specific project, such as visitation to established crisis centers, or attendance at a workshop about use of group techniques in handling juveniles.

2. **Responsibility to The Community Project:**

   a. To the Board of Directors of the Community Project, developmental phase:
      (1) Work with the DAMHS assigned board member to recruit a responsible interested board.

- (2) Involve the recruited members in becoming an incorporated organization.
- (3) Keep the board well informed about community needs and attitudes related to your client population.
  - (a) Be well informed about and sensitive to what other community care givers can potentially do for the clients, and what they feel is needed to offer adequate coordinated services.
  - (b) Be well informed about the numbers and needs of clients seeking help from DAMHS who might be served by the project.
- (4) Work with the board, your consultant, and advisory community care givers in planning the services to be offered by the community project.
- (5) Work with the board to secure financial support:
  - (a) Seek a location for the project operation.
  - (b) Seek financial donations for support of the project.
  - (c) Seek contributions of fixtures and equipment needed for the project facility.

b. To the Board of Directors of the Community Project, operational phase:

- (1) Serve as director of the project, **or**
- (2) Assist the board in recruiting a suitable director.

3. Responsibilities as Director of a Community Project:

a. Administration

- (1) Administer the project according to the policies and by-laws set up by the board of directors.
- (2) Work with your consultant on a shared responsibility decision making level, and involve him in B, C, D, and E below.

b. Staffing

- (1) Recruit and supervise any paid staff essential to the project, such as a secretary, or other non-professional trainees assigned to specific project areas.
- (2) Enlist a volunteer staff.
- (3) Provide orientation and in-service training for volunteers.
- (4) Follow up on volunteers' services to clients to increase their skills and provide safety for the clients.
- (5) When suitable, recruit a volunteer chairman who will be responsible for scheduling volunteers to assure necessary staff for each time period.

c. Client Services

- (1) Explain services available and general procedures employed.
- (2) Involve your professional consultant in evaluation and recommendation

for handling severe and/or resistant cases.

(3) Coordinate services with all other care givers involved (i.e. schools, welfare, courts, vocational rehabilitation, other community projects, etc.).

(4) Make appropriate referrals.

(5) Assign clients selectively to: (1) a volunteer; (2) a therapy group; (3) a day care center or educational facility; (4) a special tutor; (5) a counselor for one-to-one handling. (These may be provided by your own community project, or by another of the community projects.)

d. Education and Liaison

(1) Seek opportunities to present your project to civic or social groups.

(2) Accept invitations to appear on radio question-answer programs, to teach, etc.

(3) Keep other care givers informed of what services you are prepared to offer.

(4) Know what other care givers are feeling, planning, and doing.

4. **Responsibilities to Oneself:**

a. Remain a student: treat clients and developmental problems as potential challenges to new learning. Learn from reading, from the professionals, other community care givers, your volunteers, other non-professionals and the clients themselves.

b. Respect your own style and the unique opportunities afforded by having a foot in two worlds, the world of the professional care giver and the world of the potential consumer.

B. **Criteria For Selection of Non-Professional Trainees:** What professionals and non-professionals saw as most important characteristics at the close of the project. (The order in which criteria are listed has no significance.)

1. With regard to leadership qualifications, the applicant ideally:
has a need for some structure;
is not often involved in personality struggles;
has social confidence;
is relatively unimpressed with status;
is relatively at ease with authority; and
has a record of participation in community affairs.

2. With regard to qualifications for a therapist, the applicant ideally;
has an attitude that emotional upsets are most often legitimate human

experience;
is self-aware, especially, aware of his own personal needs;
feels empathy;
has a feeling of some responsibility to help others;
is self-motivated;
is moderately self-critical;
has a sense of self-esteem and self-worth even after a major error;
has relative ease admitting, "I don't know;"
is compelled neither to confess nor to hide errors; and
has intellectual ability.

C. Criteria for Selection of Consultants to Non-Professionals: What non-professionals saw as most important characteristics. (The order in which criteria are listed has no significance.)

Ideally, the consultant:
listens to problems about which I want consultation;
discusses the advantages and disadvantages of what I am doing;
demonstrates an approach I can use;
has ability to communicate specialized knowledge—can make me understand;
is a person whose judgment I respect;
is respected by other professionals in his field;
is flexible;
appreciates the potential contribution of the non-professional;
is motivated—has a desire to be involved; and
gives me confidence.

D. Training Curriculum: 1 Year Period

The curriculum below is very similar to that offered during the first project year, but not identical to the training during any single year. It is made up from the training experiences trainees viewed as most valuable, with percentage of time based on the amount of training offered to trainees who felt adequately trained.

Group Training: 10% of total time

1. TWO HOUR CLASSES AND SEMINARS, scheduled every other week:*

No. of seminars	Subject of Seminar
1	Case management
1	Case histories
2	Interviewing techniques

No. of seminars	Subject of Seminar (cont'd)
5	Psychodynamics
4	Growth and development
4	Contingency management
2	Community Organization
1	Change-change agents
2	Program development
2	Interagency relationships
2	Other, staff request

2. STAFF CONFERENCES, scheduled alternately with seminars:

For discussion of cases, community attitudes, staff relationships, and cooperative meshing of activities in various community projects. Flexibly structured.

3. SENSITIVITY GROUP–MODIFIED: **

To be scheduled weekly, for two hours. Usual T group modified with discussions of subjects which arise from the group interaction, such as handling of anger, feelings of inadequacy, ambivalence, etc., as these relate to the group members and as they may be handled in their client relationships. Also used as a vehicle for training in how to use groups techniques with clients.

Individual Training: 10% of total time

1. ORIENTATION
Two to three weeks in which to observe all activities, learn the attitudes and regulations of the organization, and begin a reading program related to the project assignment.

2. INDIVIDUAL CONFERENCES:***

Scheduled one hour weekly conferences with the director and on-demand conferences with the director and/or a consultant to allow the director to appraise and direct the trainee's over-all development, and to allow the trainee to have individual instruction about problems specific to his case load, i.e., homosexuality, retardation, etc. Also provides opportunity to get assistance with handling a client or situation troubling the trainee at any unscheduled time.

3. OUTSIDE TRAINING EXPERIENCES:

Each trainee is encouraged to choose workshops, conferences, and site visit experiences available in the area (if possible) or in the continental United States which offer in-depth training about some area specifically pertinent to the project assignment. Each trainee is expected to spend at least one week and not more than four weeks attending one or two outside training programs each year.

* Classes and Seminars: Inclusion of classes and seminars might be surprising to conference participants, since emphasis in discussion was on the individualized, on-demand aspects of training. Both throughout the project and at the conference, many professionals tended to place a relatively low value on this type of training. All groups of trainees, however, differed significantly from the project's professionals on the relative value of this type of training. All trainee groups adjudged classes and seminars to be among the most valuable of the training experiences offered.

** Sensitivity group has been included in this curriculum, though reactions to it during the project were mixed. Trainees who were offered group sensitivity instead of more structured didactic training did not see sensitivity as valuable. However, trainees who were offered sensitivity along with the more didactic type training saw it as very valuable.

*** After the first year, consultant-type individual training became the most valued form of training. It appears that during all years after the first training year, attendance at classes, seminars, sensitivity, and outside training might be left to the discretion of the trainee, with attendance at staff conferences obligatory.

Conference Evaluation
Composite Responses to Questionnaire

One month following the conference, evaluation questionnaires were mailed to 18 guest participants who attended the conference. 13 of the participants (72%) completed and returned the questionnaire. Respondents were requested to answer carefully and frankly, to feel free to point out areas of the conference which appeared to be ineffective. The following are the questions, with composite answers:

1. **Do you Feel The Length of the Conference Was:**

   1 Too short 10 About right 2 Too long

   Please Explain:

   "Too short to discuss any of the issues concerning the generalization and training of non-professional workers."

   "Would have appreciated a little more feedback from conference participants in the last session."

   "Another day would have been helpful . . ."

   "With the amount of information already mailed out, little additional information was given for the time spent."

   "The presentations were often too long or seemed that way because of emphasis on statistical material rather than process and conclusions in a general framework."

2. **What Comments Do You Have About The Size And/or Composition of The Group of Participants Chosen For This Conference?**

   "Would like to have seen more people representing the sceptics . . ."

   "Composition over-represented state and local agencies."

   "I would like to see more local people participating, raising their own questions. . ."

   "Would like more local participation . . ."

   "Could have had a more adequate representation of new careerists across the country . . ."

"Composition dichotomized between those specializing in community mental health and those whose background was primarily at state level, presenting a problem in the focus of discussion groups."

"There was an absence of Mexicans, Indians and Blacks."

"Interesting, but too large." . . . "Very good, but too large" . . . "Well balanced, but too large."

3. **Do You Feel Your Initial Expectations of The Conference Were Fulfilled?**

3 Yes, definitely 4 Yes, somewhat 3 Not sure

2 No, somewhat 1* No, definitely

Please Explain:

*"I was pleasantly surprised by what went on. I expected a dull conference where a few people did all the talking. I feel everyone participated."

"Introduction, background and overview provided a good foundation . . . did not obtain desired information on training content and evaluation procedures."

"I had heard much about the project and was eager to see the setting and meet some of the participants. I expected to relate these observations to my own activities. This I was able to do."

"Hoped for more detailed focus . . ."

"Had hoped to find out more about the tasks performed and specific problems encountered with the community."

4. **What Comments do You Have About The Resource People Who Conducted This Conference?**

"Well qualified" . . . "Interesting" . . . "Good balance" . . . "Good, well informed, broad experience, very effective." . . . "Amazingly objective" . . . "Excellent."

"Those connected with the project did a fine job. Some of the consultants spent much time on history and mutual congratulations."

"Possibly too much weighted on the side of those more concerned with damning the establishment than with critical evaluation . . ."

"Didn't provide enough detail . . ."

5. **Name The Three Aspects of This Conference Experience You Liked Most. Please Discuss.** (Dominant Pattern of Responses: Eight Respondents Mentioned Conference Staff; Seven Respondents Mentioned Groups And Panels.)

"The participating new careerists."
"Refreshing difference apparent in mix of professional, non-professionals, and other people from community."
"The degree to which both non-professionals and professionals were involved as faculty."
"Reports of activities by the trainees."
"The group discussions."
"High level involvement."
"The open dialogue near the end."
"The feedback session."
"The timely use of panels."
"The small group discussions."
"Overview and background."
"Planning and information prior to conference."
"Well structured use of time."
"General content remained relevant."
"The logical step-by-step presentation made a 'neat' package and easy recall."
Information on: "use and development of volunteers," "developmental stages of DAMHS," "training process," "consultant activities."
"The balance of participants."
"Meeting the people who were there."

6. **Name the Three Aspects of This Conference Experience You Liked Least. Please Discuss.** (No dominant pattern evident in responses.)

"The lack of sense of purpose."
"The lack of focus."
"Failed to consider impact."
"Project not criticized."
"Repetition first day's discussion with hand-out material."
"Near didactic presentations, repeating the mail-outs."
"Actual information on training would have been helpful."
"Too much formal presentation."

"The smaller group discussions."
"Should have had smaller groups for discussion."
"The final summary panel. (It did little.)"
"More time should have been devoted to applicability and generalization of results for use by others."
"Lack of involvement by minority groups."
"Location . . . transportation."

7. **Have You Gained Any New Ideas Which You Feel You Want to Try in Your Own Agency or Setting?**

8	Yes	4	No

Please Explain, Giving Specific Examples.

"Trying out trainee selection criteria on students."
"Middle class volunteers with career ladder non-professionals."
"Reinforced ideas about in-service training."
"Makes me more comfortable in being able to try exciting and innovative ideas, especially in the area of providing an opportunity for non-trained professionals to assume responsibilities such as did those in your project. Exciting and refreshing."

(Several respondents noted they had thought of or considered ideas which the conference discussed, and are trying or intend to try them.)

8. **Please give us your further comments or suggestions about all or any part of the conference experience:**

"There really isn't anything more exciting than working 'where the action is' and we have so few community development projects that have proven the theory of involvement as well. Good luck to the professional-non-professionals."

"Overall, it was a good conference, but it could have been more valuable to me if we had gone into a deeper review and discussion of such items as training curriculum, evaluation methodology, positions, duties and responsibilities, etc."

"I enjoyed it; I profited from it and was intrigued enough by the possibilities of working with non-traditional mental health workers to apply for a job (where I could do so)."

"I do not believe it was planned about any central theme. It was not a conference, but a program which was descriptive and general."

"Congratulations on a magnificent job. I only hope your final report pulls no punches and tells it like it is. Otherwise it can be a sterile story . . . Please, tell the whole truth even though it may raise the temperature a bit."

To Tell It Like It Was . . . . .

Jan Neleigh

To tell anything "like it was" is, inevitably, to tell it as someone perceived it to be. In attempting to evaluate and describe this project, my major problem has not been to decide whether to tell the truth, but rather to determine what was truth. For an in-house example: Following a rather angry staff conference, one of the staffers said, "Everyone knows what the problem is around here. I don't know why we can't face it." Shortly after this, I interviewed many of the non-professionals and asked each what, in his opinion, the problem was. I did not get two answers to the question which were in agreement.

For an example in community, we made a survey of attitudes among agency heads and randomly chosen professionals. Most agencies answered the interviewer's questions with quite positive, sometimes flattering, responses. I did not include any of the interviews in the final data because none of the agencies which I knew to oppose our program would agree to be interviewed. Most notably, none of the M.D.'s contacted had "time" to be interviewed.

The conference discussions underwrote some significant discrepancies in the opinions of the board, the professionals and the non-professionals as to how it really was. I submit that the data presented at the conference represent a composite truth. I do not pretend the comments which follow are in any sense a final statement of truth, nor are they necessarily my own opinion. They are a collection of comments about problems in community and problems in-house which I hope will give you some glimpse of the many faces of truth.

THE COMMUNITY:

From the on-set of the project, DAMHS was controversial. The M.D. community actively and passively resisted having non-professionals handle their patients, and having "free" service offered to people who might potentially pay. Active resistance was sporadic, and usually came in the form of "resolutions," passed or considered by the medical society, to request our funding be withdrawn, to refuse to underwrite comprehensive mental health services, etc. Passive resistance came in the form of not answering requests for medical information, not honoring patients' requests to be referred to DAMHS, not hospitalizing patients for short term assistance, making it necessary to send them out of town or to state hospitals, and sometimes, refusing to handle patients at all if they used our services.

DAMHS reacted many ways to medical opposition. We attempted to let the M.D.

staffers handle the relationships with other M.D.'s. That is, we requested speaking engagements for them with the medical society, and had the psychiatrists visit individual M.D.'s to try to work through problems. We attempted to correct what were and what might have been valid complaints the doctors in the community expressed. For example, trainees were accused of "prescribing medication," i.e., of suggesting clients go to the doctor and ask for medication. Doctors complained they were not informed of progress of clients, a semi-valid complaint, since the staffers were often guilty of not sending progress reports, but the doctors most often did not attend case conferences, or make any attempt to be informed. Some doctors said they did not know enough about psychiatric patients to handle them, so certainly no non-professional should be allowed to do so.

The board members of DAMHS and of the new comprehensive center took the final brunt of appeasing the medical situation. DAMHS was deliberately "killed" as an organization by the board representing people most committed to its philosophy, to allow it to be what the industrial change agent is . . . the bad guy who has to go after the changes are made.

It should be said we did have superb cooperation from some of the physicians, and nominal but comfortable and adequate cooperation from others. At no time during the project, however, did we have the cooperation or backing of the majority of the members of the medical community.

Our other most active community opposition came from the mental health association, an organization which our staffers had initially attempted to strengthen. Some members who held power positions in the association, including some mental health professionals, started relatively effective rumors about the dangers of having "untrained" people handle cases. The most active opposition from this organization came in the form of an attempt to sever the relationship of the state hospital and DAMHS, worked through a member of the state hospital board. Since we also had support on that board, the attempt did not succeed.

While the mental health association was not a care-giving agency, the inter-agency struggle had certain aspects of a power-personality struggle over a question of who was the spokesman for mental health. The problem had its roots in early co-sponsorship of the children's center. It was not effectively solved during the project.

Other brush fires in community were sporadic, sometimes based in the attitude of the individual who happened to head an agency at a given time, and sometimes started by a disgruntled client or someone in the family of a client. The non-pro may be (or he may only feel) particularly vulnerable to attack for any breach of "professionalism" or any handling which the client subsequently feels was "poor" advice.

The problems noted above probably represent the major professional concerns. If the non-professional presented problems for the professional in community relationships (and he did!), the professional and other non-professionals presented problems for the trainees who were attempting to develop projects. Some groups – at one time probation, and always AA – seemed more willing to work with the trainees than with the professionals; they resisted the mental illness connotation of DAMHS and professional handlers.

The first projects, as noted earlier, were started before they involved the community very extensively. Later trainees met resistence to DAMHS's allegedly trying to "take over everything," or "build an empire." Each project developer was, in a sense, a promoter and a change agent, and each picked up some resistance from personality conflicts which their contacts had previously had with some other staff member. When the several projects were all working under an umbrella of DAMHS, but were working for very separate organizations, one would be planning and promoting something which would seem to be or would be trespassing the support-volunteer domain of another. In a sense, each project took a part of the "blame" for what any other project or the DAMHS administration was doing.

That we had superb backing from some members of community should have been evident to conference participants. That it was adequate is also evident. It was not without pain, and whether DAMHS could have stayed in existence as a comprehensive center without the distinct break and change of leadership will, I suppose, always remain an open question.

The Organization:

The survival rate for trainees of the project was not good: eight of seventeen. Most said they left for some in-house reason. The data allowed for pinpointing of specifics among the pleasures and problems in a sense a description could not, I think, accomplish without bias. That is, certain groups of trainees reacted to some types and amounts of training, to some types of role definition, etc. The data also give a measurement to the degree to which certain groups liked and disliked other staff members, and agreed or disagreed with them. To a careful reader, the pain and pleasure are clearly evident, I think, if unstated.

I would like to comment on a dimension not cleanly handled in the data, but rather graphically demonstrated at the conference. For the purpose of evaluation, the pro's and non-pro's had filled in forms on which their anonymity was assured. On these forms, we had significant differences in perception which were not brought out in open discussion. For example, a great deal of discussion at the conference centered on allowing the trainees freedom of role design and autonomy, "turning the trainees loose." The professionals expressed this as "truth" as they perceived it. The non-pro's did not state at the conference, and to my knowledge had not in five years stated to most staff professionals, what they clearly said in the data: across groups they felt they had no more freedom of role design or autonomy than the control group, and one group of trainees felt they had a great deal less freedom than people in random ordinary jobs. In the data, similar disagreements were obvious in professional and non-professional reactions to training, and in expressions of what the non-pro wants from the professional. These differences were not expressed in the conference group discussion.

I will not pretend to pick the chicken from the egg: whether the non-professional will not talk because he does not feel he is heard; the professional does not hear because the non-professional does not talk; the non-professional is not secure enough to disagree with the professional, etc. I do think it is important that this happened: when potentially controversial statements were made, they were not challenged. We will not truly be co-workers until, right or wrong, agree or disagree, we have the courage to talk to each other — like we think it is!

Conference Roster

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***Rena Wright,** Administrative Assistant, DAMHS central administration. Member, Executive Committee, Citizen's Planning for the Southwest Comprehensive Mental Health Center, Las Cruces, New Mexico

** Non-Professional trained under Grant No. MH14821.*

DAMHS Board of Director's Members not present:

F. L. Donnini, Owner-Pharmacist, Las Cruces Drug Store

Louis Freudenthal, Retired. Owner and Former Agent, Valley Insurance Company

James Kirkpatrick, (Lt. Col., Retired), Senator, New Mexico State Senate

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